

***United States Court of Appeals  
for the Second Circuit***



**AMICUS BRIEF**





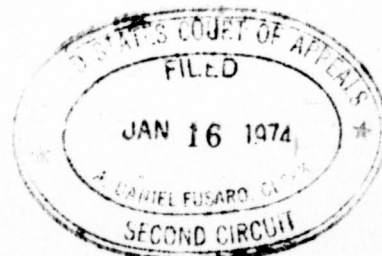
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74-2138

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

Docket No. 74-2138



JANET GOTKIN and PAUL GOTKIN, individually and  
on behalf of all persons similarly situated,

Plaintiffs-Appellants,

-against-

ALAN D. MILLER, individually and as Commissioner of  
Mental Hygiene of the State of New York, MORTON B.  
WALLACH, individually and as Director of Brooklyn  
State Hospital, CHARLES J. RABINER, individually  
and as Director of Hillside Medical Center, and  
MARVIN LIPKOWITZ, individually and as Director of  
Gracie Square Hospital,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF NEW YORK

ADDENDUM TO BRIEF OF HOSPITAL ASSOCIATION  
OF NEW YORK STATE, AMICUS CURIAE

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- 7** The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
- 8** The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.
- 9** The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
- 10** The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and

where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.

- 11** The patient has the right to examine and receive an explanation of his bill regardless of source of payment.
- 12** The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalogue of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.



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# A PATIENT'S BILL OF RIGHTS





APPROVED BY THE  
HOUSE OF DELEGATES  
OF THE  
AMERICAN HOSPITAL ASSOCIATION  
FEBRUARY 6, 1973

The American Hospital Association presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital organization. Further, the Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care.

The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed:

- 1 The patient has the right to considerate and respectful care.
- 2 The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is medically advisable to give such information to the patient, the information should be made available to an appropriate person on his behalf. He has the right to know by name the physician responsible for coordinating his care.

3 The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent, should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

4 The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.

5 The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

6 The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

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Explanation of Patient's Bill of Rights

The following points are suggested as interpretations or explanations of certain aspects of the items expressed in the Patient's Bill of Rights approved by the House of Delegates of the American Hospital Association in February 1973.

The points, as contained in the printed document, are stated in full, with the explanation immediately after. In some cases, where there is a similarity of subject matter, a joint explanation is used.

1. The patient has the right to considerate and respectful care.

This item is plain and self-explanatory. Some have suggested that, if the first item were carefully followed by hospitals, there would be no need for the 11 items that follow. The real point, however, is to furnish to the patient, who may be uninformed of his rights, a summary of the rights that hospitals for many years have recognized as belonging to the patient. The first item furnishes a logical point of beginning in explaining these rights to the patient.

2. The patient has the right to receive from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know by name the physician responsible for coordinating his care.
3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

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The second and third items deal largely with the subjects of medical information and informed consent. It was felt that many patients may not be aware of their right to obtain from their physician the necessary basis on which to base a decision. As a result, some people felt that the uninformed patient frequently acquiesced in what was recommended by the physician and had no idea what alternatives might be available. The second item particularly pinpoints that the appropriate source of this information is the physician himself and that effective communication is a real key to an informed consent. The physician should undertake to communicate in terms that he reasonably expects the patient can understand. Otherwise, the communication would be a mere formality and fly over the head of the patient. The second item also recognizes that complete information to the patient may be medically inadvisable in some instances, but this should not be used as an excuse for failing to make communication at all. In such a case, the physician should make the communication to an appropriate person in behalf of the patient. In this way, the patient or members of his family will be fully reassured that complete information to make intelligent decisions is available and that no effort is made to withhold information on the basis of any notion of a professional privilege.

Pinpointing the physician as the appropriate source of information has at least one additional advantage. In addition to those mentioned, the physician will be able to impart a great deal more useful information than the patient himself could glean on an uninstructed excursion into his own medical records. It should also reduce any imposition on the medical records department from patients and former patients who simply wish to gratify curiosity or to relive their hospital stays by idly perusing medical records. It is recognized, of course, that various circumstances could justify a patient's direct access to his medical records.

As the greater number of patients become advised of the fact that there is a principle of informed consent that is respected by hospitals and their medical staffs, they may approach the health care team with greater confidence. Also, as the patient has greater opportunity of making an informed decision, it is quite possible that there will be greater satisfaction with the care received and less inducement to lawsuits allegedly based on failure of the physician to furnish them adequate information to make a decision. If the public is actually informed, bona fide litigation of this type may soon disappear.

In the third item, explanation is given as to when specific information for an informed consent is not necessary or may be excused. This is reflective of general principles of law developed in the various jurisdictions. It is also recognized that, where it is deemed material by the patient, the patient will be entitled to know the members of the health team that will deal with him. This



should help to offset any notion the patient may have that he is being dealt with impersonally and by anonymous persons who are not subject to accountability. Where the identity of a particular person is not material to the patient, there is of course no need for any formality of introduction or disclosures that could delay or interfere with treatment.

4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.

The fourth item deals with a very important issue, namely, the fact that a patient, at least an adult patient of sound mind, has the right to refuse treatment to the full extent that applicable law will permit. By informing the patient of this right, no particular philosophical point of view is expressed. The patient is simply told that, except where the law interposes itself, he has the right to refuse treatment. The statement takes the law as it finds it in the various states and, of course, the laws on the subject will differ among the various states. For instance, it is possible for one state to recognize that under certain circumstances the patient has the "right to die." The fourth item does not interfere with this right. In other states, a similar decision by the same patient might be prohibited by law, which could construe the decision as an unlawful attempt at suicide; again, the Bill of Rights does not undertake to either enlarge or diminish the legal rights of the patient, but assures him that, whatever those rights may be, they will be respected.

In passing, it should be observed that the right to refuse treatment also calls for an informed consent. The patient wishing to refuse treatment is entitled to be advised of the medical consequences of that decision.

5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.
6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

The fifth and sixth items assure the patient that his right of privacy will be respected. This applies to all aspects of his treatment and oral and documentary information. This is a right that is generally

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protected by the hospital as a part of its "considerate and respectful care" referred to previously. It is also consistent with legal requirements made by the laws and regulations of several states and made a condition of various programs, particularly those having a governmental sponsorship, of health care delivery.

7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

The seventh point assures the patient that the hospital will make a reasonable response to his request for service. This does not mean that every caprice or desire can or should be satisfied. It very definitely means, however, that the hospital cannot ignore or refuse the patient's reasonable request. What is a reasonable request must, of course, be determined by the circumstances prevailing in relation to the request. The nature of the request, the medical needs of the patient, the resources available to the hospital in personnel and equipment, the urgency of the patient's case and the relative needs of other patients will, among other things, indicate in a given case what a reasonable response should be. Also, in matters of ethics or religious beliefs, a reasonable response would surely not require a hospital to abrogate its corporate commitment or its personnel to violate conscientious principles.

The seventh item also reassures the patient that he will not be transferred when it is inconsistent with his medical needs or there is no assurance that an available institution will receive him. Otherwise, the discharged patient would not really be receiving a transfer. No one favors a policy of transferring a patient who needs further institutional care until arrangements have been made for that further care.

8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.
9. The patient has the right to be advised if the hospital proposes to engage in or perform human

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experimentation affecting his care or treatment.  
The patient has the right to refuse to participate  
in such research projects.

The eighth and ninth items are intended to dispel another form of ignorance that may have made the patient apprehensive and suspicious of health care services. If relationships between the hospital and any other institution, or the relationships between any individuals who make up the health team, seem to be material to the patient, he is assured that the existence of those relationships will not be withheld from him. This aspect may have little relevance except in some of the larger metropolitan areas where it is found expedient for more than one institution to share in the care of the same patient. For instance, hospitalization may occur in one institution and medical or ancillary services may be largely provided by another institution. Uncertainty about this type of situation has seemed to trouble some of the patients involved. The ninth point, relating to the possibility of human experimentation, is actually embraced within the earlier discussion of an informed consent. The misapprehension of undisclosed experimentation has caused such alarm that specific mention of this point was thought to be helpful and reassuring.

10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.

The tenth item reassures the patient that he will have reasonable continuity of care. In the absence of this item, many patients could feel that the hospital is indifferent to their reasonable convenience and preferences. Once again, the right of the patient must be qualified by a reasonable standard. The patient should not be given to understand that every caprice or desire will be met. To do so would prejudice the rights of the other patients, as well as unduly impose on the hospital and members of the health care team.

It also assures the patient that, upon discharge, he will not be left in helpless ignorance of his continuing health care requirements. The latter is essentially a medical responsibility, but the hospital is as interested in this aspect of the patient's welfare as it was in assuring reasonable quality of care while the patient was within the hospital environment. The hospital cannot guarantee the performance of the physician in this regard, but it can provide a mechanism that will call for continual medical staff responsibility from admission through final discharge.

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11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.

The eleventh point assures the patient that he has a right to know what he is expected to pay for. It is as simple as that, but some people felt that many patients were unaware of the system of hospital charges and the fact that the hospital bill is tied into the services that have been furnished. As a matter of fact, any hospital would have to make the same disclosure to collect an unpaid account in the courts. The records must be kept, and no one should hesitate to let the patient know what he is expected to pay for.

12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

The twelfth item may seem unnecessary to many. Since the hospital must establish rules and regulations for the conduct of patients, as well as visitors and other nonpatients, the hospital very naturally expects to bring those rules and regulations to the attention of those who are expected to conform. Many effective means have been developed by the hospital for the simple purpose of communication. On the other hand, some patients fear that many rules and regulations will serve to trap the unwary. Once again, ignorance must be dispelled. It is to the advantage of the hospital that its rules and regulations be communicated to all persons affected. The twelfth item also furnishes a very logical connection of the "Bill of Rights" and the corresponding obligations and responsibilities that fall on the patient who is to enjoy those rights. Many hospitals will find it appropriate and convenient to provide in the same document both rules and regulations and a copy of its own statement of the Patient's Bill of Rights. This could help assure that the patient will be simultaneously advised of what he can expect from the hospital and what the hospital is expecting from him.

It is only coincidental that the title has any legal association. Although many items contained in the statement are consistent with generally accorded legal rights, the statement itself is not, and is not intended to be, a legal summary. It just happens that some of the rights recognized in the statement have been previously assured by legislation or court decisions. Legal recognition of any rights should not prevent the hospital from expressing its concern about the various subjects and should not detract from the scope of information being presented.

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A Report on Action Regarding AHA's Bill of Rights

The American Hospital Association's Patient's Bill of Rights has stimulated a variety of actions and reactions. It has earned the support of many organizations and agencies that are part of or related to the health field. The Maryland State Legislature took action urging the state's hospitals to endorse the AHA's statement. In Pennsylvania, Insurance Commissioner Denenberg, having initially labelled the AHA document a "public relations stunt," has seen fit to develop and issue a "Citizens Bill of Hospital Rights." In this document Mr. Denenberg quotes several of the points brought out in the Association's document. The California Hospital Association endorsed the AHA Bill of Rights, but is opposing a bill in the state legislature which would make that document law in California.

Some hospitals have reprinted the AHA's Patient's Bill of Rights for employees or patients without comment from administration or governing board. Some have indicated that they have always supported these and other rights of patients, and no action of adoption or comment seemed necessary. These rights are, in their opinion, facts of life which need no further embellishment. Many hospitals have printed the rights in their employee bulletin and one hospital reprinted the Bill of Rights in full on parchment-like paper stock for posting on its bulletin board and in public places. The latter institution is the Columbia Hospital in Milwaukee.

In other hospitals, either administratively or through governing board action, the AHA's Patient's Bill of Rights has been formally adopted or endorsed. The University of Chicago Hospitals and Clinics endorsed the document, issued a press release to that effect, and reprinted the Bill of Rights in a leaflet form for distribution to staff and patients. The Berkshire Medical Center, in Pittsfield, Massachusetts, endorsed the Bill of Rights and reprinted it in its employee publication, devoting the entire issue to the subject. Barnes Hospital in St. Louis abbreviated the 12 points in the AHA's document, and in its employee publication, stated that these were "guidelines" Barnes had always subscribed to, but that putting them in writing "can be a reinforcement for hospital personnel and...make the patient more comfortable about his relationship with the hospital."

At the Duke University Medical Center, Durham, N.C., the Committee on Patient Services and Personnel Relations accepted the principles contained in the AHA Patient's Bill of Rights, but modified that document in a narrative statement, "Your Rights as a Patient at Duke University Medical Center." Covering essentially the same points as the AHA's document,



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this statement was circulated among all personnel with a statement emphasizing the "importance of each member of the hospital community to the principles described therein..." At the Commonwealth of Massachusetts Soldiers' Home in Chelsea, the AHA's statement served as a "stimulus" in the preparation of a "Philosophy of Medical Care at the Soldier's Home" which the commandant requested be "translated to practice."

These examples are by no means all that could be cited to demonstrate action by the field with reference to the AHA's Patient's Bill of Rights, but they do serve to indicate the kinds of action being initiated in that regard. It is clear that the AHA's development and issuance of its Statement on a Patient's Bill of Rights has served to stimulate many hospital officials to support the principles on which the document is based, to rethink their institutional practices, and to reinforce their practices by publicly proclaiming a set of patients' rights.

Quite a number of hospitals have as yet taken no action with regard to the AHA's document, indicating that they are awaiting the development of these informational materials from the Association.

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A Memorandum to the Administrator, Chairman of the Governing Board and  
Chief of the Medical Staff

From John Alexander McMahon, President of the American Hospital  
Association

I would like to comment briefly about patients' rights and about the recently issued AHA document, its Statement on a Patient's Bill of Rights. No previous document produced by your Association has elicited more interest and excited more public comment, as well as comment from within the field.

The public response to that statement was overwhelmingly commendatory to the hospital industry, as we have tried to point out. It was lauded as "admirable," as "wise and compassionate," as "a realistic and explicit response to legitimate criticism and concern," as "a vast step forward in allaying the patient's fear of the unfamiliar and the unknown."

Nature of the Document

The publication and distribution of such a document listing patients' rights may well be unusual, but certainly the principles contained in ours are not. Actually, the AHA's Patient Bill of Rights is simply a codification of those moral and ethical tenets which are already commonly adhered to by those concerned with the provision of health care.

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Although many items contained in this document are consistent with generally accorded legal rights and some of the rights have been previously assured by legislation or court decisions, the AHA's Bill of Rights is not--- I repeat not---a legal document. Rather it is a set of guidelines for hospitals to follow in publicly attesting the quality of the treatment their patients may expect. Each hospital is free to choose to endorse the AHA Bill of Rights, to write one of its own, to adapt the Association's document, or not to make a public statement about patients' rights at all.

The AHA statement is not required of any hospital unless and until that hospital's governing board or other authority takes an action to approve it and make it so. It is intended primarily to make sure that the patient knows he has certain rights and to give him assurance that the hospital recognizes and respects those rights.

An examination of the 12 points listed in our Patient's Bill of Rights shows clearly that they are not unusual. They are, in fact, no more and no less than an enumeration of the rules of conduct commonly observed in the hospital setting. While some of them may at first glance appear complex and to present concern to hospital administrators and physicians, they are hardly more than any of us would hope for under the same circumstances.



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Purpose of the Document

Why, then, you may logically ask, has the Association developed and issued this Patient's Bill of Rights at this time? Let me try, in both an official and personal kind of way, to answer that question.

The Patient's Bill of Rights represents an attempt to identify and publicly state what a patient has a right to expect from the hospital, its physicians, its personnel, and all others associated with it. These areas of concern to the patient were identified in a cooperative venture that began with the Committee on Health Care for the Disadvantaged, an AHA Board Committee which brought together hospital administrators, hospital association and planning agency executives, attorneys, physicians, and consumers. Their work was augmented by suggestions developed in reviews by the AHA's Regional Advisory Boards composed of members of its House of Delegates, by its Committee on Physicians, and by the Association's legal counsel.

Fundamental to the Patient's Bill of Rights is the awareness that the healing process in the modern medical setting tends to involve increasingly more complex relationships. As medical science expands our ability to save lives and restore good health, it also tends to involve a growing array of individuals in the process. This makes the important matter of good communication even more important than ever before. It is our hope that the AHA's Patient's Bill of Rights, or more accurately the principles it sets forth, will help to offset possible breakdowns in

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mutual understanding by anticipating where such breakdowns might occur and by providing guidelines for all who are involved. It is our belief that by clarifying the rights of patients in a hospital, their needs, as well as the needs of the physician and of the hospital, are well served.

Our statement seeks to reassure the patient that all those with whom he comes in contact are aware of his needs and that he may rightfully expect them to be sensitive to these needs. It also attempts to anticipate many of the fears which, although they have not always been clearly articulated, are known to be shared rather widely by those who are hospitalized.

The Patient's Bill of Rights was developed in recognition of two factors that have special implications for the physician and the hospital. First it recognizes that an informed patient is a more receptive patient. The patient who understands the nature of his illness and his treatment tends to be less apprehensive, more relaxed, more cooperative and, therefore, tends to respond better and more quickly to the program of treatment outlined for him.

Secondly, the Patient's Bill of Rights recognizes that a better informed patient, one who has had adequate information to participate in decisions that affect him, is less likely to be dissatisfied with the outcome of his treatment. By dispelling apprehension and by emphasizing the need

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to fully inform the patient on matters requiring his consent, it is our belief that the AHA's document improves the prognosis of the patient and reduces the vulnerability of physician and hospital to the consequences that misunderstanding so often breed.

View of Physicians

I clearly recognize that the AHA's action in developing and distributing its Bill of Rights, has been a source of some concern to physicians and physician bodies. But I was heartened to read a piece by Dr. James J. Gill, in Medical Insight for March 1973, who had read about the AHA's Bill of Rights first on the front page of a Bombay newspaper. In his article entitled, "A Doctor's Dilemma," he expresses grave concern at his own ability to live up to the rights expressed in our document, then concludes with the following:

"But seriously, I think the A.H.A.--by widely circulating among the American population this 12-point 'bill of rights'-- is going to force us physicians to do more than we have in the past to provide satisfactory responses to the questions, fears and uncertainties of our patients. Encouraged to feel entitled to adequate replies, they will be asking more and more difficult questions which we, in time, will have to learn to handle. Certainly they will sometimes be requesting information we know might distress or confuse them. But the undesirable alternative to the doctor's giving appropriate answers will continue to be, just

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as it has been in the past, his brushing aside the spoken or unspoken questions and feelings of patients and manifesting a paternalistic 'leave all the decisions and responsibilities to me' attitude. If the A.H.A.'s declaration of rights conveys any single, solid, implicit message, it is that patients should realize that they have a co-responsibility (shared with their physicians) for the kind of care and treatment they receive."

Dr. Gill goes on to say: "The AHA publication, which will be thoughtfully considered by millions in the U.S. and all over the world during the years just ahead, will affect the relationship between doctors and patients in a most profound way. One would hope that every physician would soon devote some of his valuable time to meditating upon the implications of this 12-point document. It is destined to enhance the humanity of both the medical practitioner and those he is challenged and privileged to serve. I think the American Hospital Association deserves our gratitude."

Dr. Gill has recognized in the AHA document the challenge it presents each of us in the health care industry, and has thoughtfully placed it squarely before us. I have no doubt that we are up to it.

The Patient's Bill of Rights, as we see it, is something more--an educational device that offers the hospital the opportunity to remind its employees for whom it is legally responsible, of the rights of the patient. Recognizing

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that any chain is only as strong as its weakest link, the Bill of Rights offers the hospital a means to keep continually before all personnel a reminder of the kind of treatment the patient has a right to expect and receive.

I believe the Association's document spells out clearly the principles of patient relations adhered to by the vast majority of hospitals in this nation, and in a form that can assist the individual hospital in assuring that the principles it believes in are adhered to at entry level. In adopting this or another Bill of Rights, the hospital should avoid the appearance of grandly conferring or granting any new rights, but rather supporting the traditional attitudes of the institution.

Adopting Your Own Statement

The Association's Patient's Bill of Rights was not designed, nor could it have been, to solve every problem or resolve every issue that may arise where patient relations are concerned. We believe it does, however, offer guidelines and a concrete demonstration of good faith to encourage a spirit of mutual cooperation among patient, physician, and hospital administration.

If your hospital is considering developing its own bill of patients' rights, you may find it appropriate to make modifications that accommodate local law or custom prevailing in your community. And special provisions should be inserted to emphasize any special or unique situations. For

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example, the hospital availing itself of a right of conscience may wish to point out specifically that its "reasonable response" to a patient's request would not include permitting treatment such as sterilization or abortion on demand. A point might be made, in a state where it is legally established that a person has the right to refuse treatment to the point of suicide or euthanasia, that the institution would not receive or continue hospitalization of a patient who insisted on that legal right.

Thus it is suggested that the patient's right to refuse treatment and his right to receive a "reasonable response" to his requests would be qualified by a phrase such as "consistent with the institution's corporate obligations and policies and its moral and religious beliefs." It should probably be mentioned, in hospitals where it is appropriate, that sterilization and abortion on demand are not available, to reduce any controversy if those issues arise during the course of a patient's hospitalization.

In developing a rights document, the hospital is cautioned to avoid the specification of rights that it is not prepared to fulfill. And, since a Patient's Bill of Rights coincidentally reflects generally accorded legal rights, a hospital may wish to obtain legal consultation to assure compliance with local variations of the law and terms of insurance coverage and to avoid, particularly in making modifications of the AHA's document, any new legal implications that are not specifically intended.

PATIENTS' RIGHTS  
IMPLEMENTATION/INFORMATION

Certainly adoption of the Association's Bill of Rights is not a requirement for membership, as has been asked. It was drafted with full respect for the autonomy of each and every one of our member institutions. Adoption of the bill is not an obligation, but we do believe it offers an opportunity to the hospital and its medical staff to formally and publicly reaffirm their commitment to acting at all times in the interests of the patient.

I hope you will join the American Hospital Association in that reaffirmation, through adoption of some rights document, and add your voices to this pledge, in the public interest and in the interest of the health care industry we all represent.

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PATIENTS' RIGHTS  
IMPLEMENTATION/INFORMATION

A Checklist for Implementing a Patient's Bill of Rights

The following represent check points which may be helpful in your institution should you decide to implement the AHA's Patient's Bill of Rights or develop and implement one of your own.

1. Has the document been reviewed with and does it have the support of the Board of Trustees? The medical staff?
2. Has the document been reviewed with and does it have the support of the administrative staff?
3. Has the document been reviewed with and does it have the support of the department heads and supervisors?
4. Has a program been developed with realistic timetables for introducing the document to employees? Volunteers?
5. Has responsibility been fixed for conduct and follow-up of the internal introduction?
6. Has action been taken to make patients' rights and your document an integral part of the orientation and re-orientation process?
7. Has the document been reviewed by the hospital's legal counsel and by its liability insurance agent?
8. Has it been ascertained without question that the hospital can live up to the rights it proclaims in its document?
9. Has a program been developed for getting the rights document before patients and visitors? Using your own printed pieces? Using AHA's printed pieces? Posting in public places?
10. Has a program been developed for making the community aware of the institution's adoption of a rights document? Through newspaper stories, editorials, speaking engagements, etc.?
11. Has consideration been given to the appropriateness of including in the same printed document not only the institution's bill of rights, but also the rules and regulations on the conduct of patients and any other position paper on the responsibilities of the patient?

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PATIENTS' RIGHTS  
IMPLEMENTATION/INFORMATION

Patient's Bill of Rights Questionnaire

Please complete and return to : Mr. Lee Block, Director  
Bureau of Public and Community Relations  
American Hospital Association  
840 North Lake Shore Drive  
Chicago, Illinois 60611

For your convenience, a postage-free, return envelope is attached.  
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1. Our hospital has taken official action (by Board vote or otherwise) to endorse the AHA's Patient's Bill of Rights. ☐ Yes ☐ No
2. Our hospital has accepted the principles embodied in the AHA's Patient's Bill of Rights and expect that our personnel will assure these rights to our patients, but we have not taken any official action as described above to endorse or adopt the document. ☐ Yes ☐ No
3. Our hospital has taken official action as described earlier to endorse an adapted version of the AHA's Patient's Bill of Rights. ☐ Yes ☐ No
4. Our hospital has taken official action as described to endorse a patient's rights document developed locally without reference to the AHA's document. ☐ Yes ☐ No
5. If your answer to any of the above four questions is yes, please indicate what your hospital is doing to implement the rights document (for example, educational meetings for personnel, letters from hospital officials to personnel, printing your own brochures or posters, stories in the employee newsletter or other publications, news release to local news media, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. If your answer to all of the first four questions is no, please indicate whether your hospital plans to initiate any action regarding official recognition of patients' rights, and if possible explain what form that may be. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. What materials in this kit did you find useful in explanation, implementation or publicity with regard to a patient's rights document?

PATIENTS' RIGHTS  
IMPLEMENTATION/INFORMATION

- a. Checklist \_\_\_\_\_
- b. Explanation of Bill of Rights \_\_\_\_\_
- c. Action regarding Bill of Rights \_\_\_\_\_
- d. McMahon memorandum to Administrators  
and Board Chairmen \_\_\_\_\_
- e. Public response to Bill of Rights \_\_\_\_\_
- f. Implications for training & education \_\_\_\_\_
- g. Sample press releases and editorials \_\_\_\_\_
- h. AHA printed brochure and poster \_\_\_\_\_

8. Please give us your comments regarding additional ways in which we may be helpful to you in implementing or publicizing the patient's bill of rights. \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

(We would appreciate receiving copies of your hospital governing boards resolution and your version of a Patient's Bill of Rights, samples of any printed materials you have used in your implementation and/or publicity, or any materials prepared for educational or informational purposes.)

MODEL LEGISLATION ON THE RELEASE OF  
MEDICAL RECORD INFORMATION

(WORKING DRAFT OF AMERICAN HOSPITAL ASSOCIATION)

Except as otherwise provided by law, no medical record administrator or custodian of the medical records of patients of a hospital or other health care institution shall be required to accede to a request or an authorization for release of information from medical records, or copies of medical records or parts thereof, of a present or former patient unless, upon payment of any reasonable charges for such service:

- a. The authorization is in the form of a subpoena or other lawful process of a court or administrative tribunal;
- b. The request is made in writing by the patient, if he is an adult and is believed to be of sound mind;
- c. The request is made for diagnostic or therapeutic information by a person licensed to practice medicine or dentistry representing himself as being engaged in providing medical or surgical care or treatment to the patient and requiring such information for the care and treatment of the patient under such circumstances that the delay of processing a routine consent or authorization would jeopardize the health of the patient; or,
- d. The request is made upon presentation of an authorization which is in writing and:
  1. Is addressed to the hospital or other health care institution specifically or in general terms that plainly include the hospital or health care institution;
  2. Designates each person, firm, corporation or public body to which the information or copies of records may be released, which firm, corporation or public body shall not be the signatory of such authorization, and, in the case of a firm, corporation or public body, the authorization is furnished by a partner, corporate or public officer, attorney, actuary, underwriter, personnel director, claims adjuster or other responsible agent thereof who has ostensible or written authority from the firm, corporation or public body to receive the information in its behalf;

3. Plainly designates the illness and/or period of time to be covered as to which the authorization is to be restricted by the custodian, which restriction shall be respected by the custodian;
4. Plainly identifies the specific type of information to be released from the medical record;
5. Bears the date of execution and duration of validity;
6. Is signed by the patient or someone lawfully authorized to act in his behalf;
7. A photocopy of other facsimile of the authorization is furnished to the custodian or, when the custodian has reasonable basis for doubting the authenticity or accuracy of the photocopy or facsimile thereof, the original authorization is so furnished.

Any authorization for the release of information from medical records or copies of medical records to a third party, contemplated herein, shall not authorize the further release of such information or copies by such third party, unless such further release is expressly authorized in the original authorization.

9/9/74

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PROPOSED STATEMENT ON PATIENT ACCESS  
TO HIS MEDICAL RECORD

(WORKING DRAFT OF AMERICAN HOSPITAL ASSOCIATION)

The primary purpose of the medical record is to document the course of the patient's illness and treatment. As such, it serves as a basis for the planning and evaluation of individual patient care and for communication between the physician and other professionals contributing to this care. The primary purpose determines the basic content and format of the patient's record, provides a basis for justifying the inclusion or exclusion of information, and embodies the advantage of a unit record system. Other extremely important uses of the medical record include medicolegal applications, research, education, statistics, and validation of insurance claims; however, these are secondary. In fulfilling its purpose of documenting information pertinent to medical care, the medical record is written in a language and style that meet the need for concise and effective communications among physicians and other health professionals contributing to the patient's care. In this context, it is a complex, technical document containing abbreviations, symbols, phrases, and terminology often unfamiliar to the layman.

Although the medical record is maintained for the benefit of the patient, the physician, and the hospital, it is recognized as the property of the hospital. Despite this property right, the control over the use of the record is not vested in the hospital to the exclusion of all others. Legal, ethical, and administrative considerations influence the determination of who has the authority to grant permission for release of medical information.

It is generally agreed that the patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. Traditionally, this

information has been transmitted to the patient verbally rather than in written form.

The advantages of providing the patient with brief written reports of treatment are significant.

- . Individuals who possess a report of their medical information throughout their lifetime would become more knowledgeable about their health.
- . The accumulation of these reports from multiple sources would constitute a concise, up-to-date, unified summary of an individual's illnesses and treatments.
- . The immediate availability of these reports during any subsequent treatment would provide ready communication between health professionals, thereby avoiding unnecessary delays and duplication of services and increasing the quality of care and reducing costs.

Currently very few state statutes recognize either direct or indirect patient access to his medical record. Those states recognizing indirect access generally permit access through the patient's legal representative and/or his physician. In the absence of any legislative guidelines, the parameters, if not the very existence, of the patient's right to access is unknown or, at best, ambiguous. Even where the right to indirect access is recognized, it would appear that the requirement of legal representation can be prohibitively expensive, time-consuming, and inconvenient to the patient. In addition, it would appear that such requirement could encourage a litigious attitude or posture on the part of the patient. Recognition of the patient's right to access must of course be balanced with the administrative burden imposed on the institution to the mutual benefit of both. In most cases the need for medical record information could be satisfied by the provision of a written report of the patient's diagnosis, treatment, and discharge instructions.

It is therefore recommended

1. That statutes be enacted in all states recognizing the patient's right to access to the information contained in his medical record.
2. That hospitals and other health care institutions be urged to establish policies providing for patient access to this information with interpretation by his physician or other designated person(s).
3. That consideration be given to providing the patient, upon request, a brief written report of his care.

9/10/74

DRAFT C

FOR DISCUSSION

IN THE GENERAL ASSEMBLY

STATE OF \_\_\_\_\_

## A BILL

To Provide For Confidentiality  
Of Medical Information

1 Be it enacted by the People of the State of

2 \_\_\_\_\_, represented in the General Assembly:

3 Section 1. This Act may be cited as the "Confidentiality  
4 Of Medical Information Act".

5 FINDINGS AND DECLARATION OF PURPOSE

6 Section 2. (a) The General Assembly finds --

7 (1) The relation between a physician and his  
8 patient is a confidential one. The patient should  
9 feel free to make a full disclosure of facts to  
10 his physician, in order that the physician may  
11 most effectively render his services. This can  
12 only occur when the patient is free to make the  
13 disclosures necessary for proper treatment with  
14 the knowledge that the physician will be able to respect  
15 the confidential nature of the communication.

16 (2) Physicians already have a professional  
17 duty to maintain the confidentiality of physician-  
18 patient communications and may release such infor-  
19 mation only upon proper authorization from the  
20 patient or in accordance with requirements of the law.



1           (3) Requests by third parties, including  
2 insurance companies, private employers and govern-  
3 ment, for release of confidential medical infor-  
4 mation are often deficient in that they do not:

5                 (A) delineate the specific information  
6 sought,

7                 (B) place any limits on the use of such  
8 information,

9                 (C) restrict the transfer of such infor-  
10 mation to others,

11                (D) agree to afford the patient future  
12 access to such information for purposes of  
13 reviewing same for accuracy, completeness,  
14 timeliness or pertinence.

15           (4) Some third parties are not maintaining  
16 the confidentiality of those physician-patient  
17 communications. This failure breaches the other-  
18 wise confidential physician-patient relationship,  
19 thereby discouraging patients from revealing  
20 necessary medical information which might prevent  
21 a physician from rendering his services most  
22 effectively.

23           (5) Advancements in automated data processing  
24 have increased the capacity for gathering, storing,  
25 and transferring confidential medical information  
26 as well as increasing the possibilities of  
27 3/ unauthorized access to and use of such information.

1 (b) The purpose of this Act is to establish  
2 safeguards for maintaining the integrity of confidential  
3 medical information.

4 DEFINITIONS

5 Section 3. For purposes of this Act --

6 (a) The term "patient" means a person, including  
7 a minor or legally incompetent individual, who for the  
8 purpose of obtaining diagnosis, treatment or medical  
9 evaluation consults a physician, or who receives  
10 such services from a physician.

11 (b) The term "physician" means all persons  
12 lawfully practicing medicine in this State.

13 (c) The term "third party" means any person or  
14 entity other than the patient or his physician.

15 (d) The term "confidential medical information"  
16 means: (1) all information regarding an individual's  
17 medical history, condition, or treatment communicated  
18 by the patient or other person on the patient's behalf  
19 to the patient's physician or his agents or employees  
20 during the course of the physician-patient relationship  
21 or to a hospital or other health care facility or its  
22 agents or employees, and (2) all information developed  
23 by the patient's physician, his agents or employees,  
24 or other persons or entities relating to the diagnosis  
25 or treatment of the patient.

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- 1           (e) The term "physician-patient relationship"  
2 means that relationship existing between a patient and  
3 a physician during that period of time in which the  
4 patient is consulting a physician for diagnosis, treat-  
5 ment, or medical evaluation, or is receiving such services
- 6           (f) The term "medical peer review committee"  
7 means a committee of a state or local professional  
8 medical society or of a medical staff of a licensed  
9 hospital, nursing home or other health care facility  
10 or other organization which is duly formed and authorized  
11 to evaluate health care.

12           RESTRICTIONS AGAINST RELEASE OF

13           CONFIDENTIAL MEDICAL INFORMATION

14           Section 4. (a) - Patient Consent For Release Of  
15 Confidential Medical Information - Any person or other  
16 entity requesting an individual to consent to a release  
17 or transfer of his confidential medical information shall  
18 furnish such individual with a consent form containing  
19 at least the following: (1) the reason for such person  
20 or entities need for such information, and the proposed  
21 use of such information, and, (2) a statement that, if  
22 the individual so consents, that such information will  
23 be used only for the stated proposed use, and will not  
24 be given, sold, transferred, or in any way relayed to  
25 any other person or entity without first obtaining the  
33 26 individual's additional written consent on a form

1 stating, at least, the need for the proposed new use of  
2 such information or the need for its transfer to another  
3 person or entity, and, (3) a statement that such consent  
4 applies only to the release or transfer of confidential  
5 medical information existing prior to the date such  
6 consent is signed.

7 (b) - Security Procedures Required - A person or  
8 other entity receiving and retaining an individual's  
9 confidential medical information must establish security  
10 procedures sufficient to maintain the confidentiality  
11 of such information, including at least the following  
12 procedures: (1) No more than \_\_\_\_\* number of persons  
13 in the current employment of such person or entity shall  
14 be permitted access to an individual's confidential  
15 medical information which includes information from  
16 which the patient can be identified. Additional em-  
17 ployees may have access to those portions of an indi-  
18 vidual's confidential medical information which do not  
19 contain information from which the individual can be  
20 identified. (2) The identification of an individual

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\*It is suggested that as minimum number of persons as is consistent with operating requirements be allowed access to those portions of an individual's confidential medical information which contains information from which the individual can be identified, but that the specific number should be determined by the state legislature after consideration of various points of view.

1 or individuals who have responsibility for maintaining  
2 security procedures for confidential medical information.

3 (3) The provision of a written statement to each employee,  
4 who has authorized access to confidential medical in-  
5 formation which contains information from which an  
6 individual can be identified, as to the necessity of  
7 maintaining the security of such information, and of  
8 the penalties provided for in this Act for the unauthorize  
9 release, use, or disclosure of such information;  
10 receipt of such statement shall be acknowledged by such  
11 employee signing and returning same to his employer.

12 The employer shall furnish his employee with a copy of  
13 the signed statement, and shall retain the original  
14 thereof. (4) Take no disciplinary or punitive action  
15 against any employee who brings evidence of violation  
16 of this Act to the attention of any person or entity.

17 (5) Take such other physical, technical, and procedural  
18 safeguards as may be reasonably necessary to protect  
19 confidential medical information from an unauthorized  
20 release, transfer, access, use, or a threat of hazard  
21 to the security of the system containing such information.

22 (c) No person or other entity shall release or  
23 transfer an individual's confidential medical information  
24 to any other person or entity without the written consent  
25 of such individual, except in the following situations:

26 (1) to a physician or other medical personnel for diagnosi

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1 or treatment of an individual in an emergency, or,  
2 (2) to agencies of the local, state, or federal gov-  
3 ernment as may be specifically required by statute or  
4 by court order, which court order may be granted at an  
5 ex parte hearing in those cases where it is demonstrated  
6 on a prima facie basis to the court that the physical  
7 or mental condition of an individual whose confidential  
8 medical information is sought is of an imminent and  
9 serious danger to the physical or mental health of  
10 another person or to the security of the United States,  
11 or, (3) during the course of the physician-patient  
12 relationship to persons authorized by the patient's  
13 physician to receive such information for purposes of  
14 assisting in the diagnosis, treatment, or medical  
15 evaluation of the patient.

16 INDIVIDUAL'S RIGHT OF ACCESS  
17 TO AND MODIFICATION OF HIS  
18 CONFIDENTIAL MEDICAL INFORMATION  
19 IN POSSESSION OF THIRD PARTIES

20 Section 5. (a) A physician, when forwarding an  
21 individual's confidential medical information to a  
22 third party on authorization of such individual, may  
23 indicate which parts of such information, if any, are  
24 not to be disclosed to such individual.

25 (b) An individual shall have the reasonable  
26 right of access during normal business hours, without



1 charge, to his confidential medical information in the  
2 possession of any third party, except for those parts  
3 of such information as the individual's physician may  
4 have indicated are not to be disclosed to the individual.

5 (c) An individual may receive upon request, and  
6 at a cost no greater than that to the third party for  
7 producing same, a copy of all his confidential medical  
8 information in the possession of any third party, except  
9 for such information, if any, as the individual's  
10 physician has indicated is not to be disclosed to him.

11 An individual, after reviewing his records, may request  
12 of the third party the amendment or expungement of  
13 any part he believes is in error or no longer relevant,  
14 or the addition of any recent relevant information.

15 The third party must notify the individual's physician  
16 of any such request, specifically indicating those parts  
17 of such confidential medical information sought to be  
18 amended or expunged. Where the individual's physician  
19 concurs with the request, the third party may, if it  
20 chooses to do so, modify the individual's confidential  
21 medical information accordingly; however, except upon  
22 court order, the third party shall not modify such  
23 information where the individual's physician does not  
24 concur with the requested amendment or expungement. In  
25 any event, the individual shall have the right, if such  
26 a request is denied by a third party, to place into the  
27 file a statement of reasonable length of his view as

1 to the correctness or relevance of existing informati  
2 or as to the addition of new information. Such  
3 statement must accompany that part of the record in  
4 contention at all times.

5 LIMITATIONS ON LEGAL PROCESS FOR OBTAINING  
6 CONFIDENTIAL MEDICAL INFORMATION

7 Section 6. (a) Any person or other entity to whom  
8 a demand is made by compulsory legal process for the  
9 release of an individual's confidential medical  
10 information shall make reasonable efforts to notify  
11 the individual of such demand prior to releasing such  
12 information. This subsection shall not apply to those  
13 specific situations described in Section 4(c) of this  
14 Act where an individual's confidential medical informati  
15 may be released or transferred without his consent.

16 (b) (1) In any civil or criminal case, in proceeding  
17 preliminary thereto, and in legislative and administrati  
18 proceedings, an individual's confidential medical infor-  
19 mation shall not be subject to compulsory court process  
20 except as provided in sub-paragraph (2), and an indivi-  
21 dual or his authorized representative has a privilege  
22 to refuse to disclose, and to prevent a witness from  
23 disclosing, his confidential medical information in  
24 any such proceedings.

25 (2) The exemption from compulsory court process  
26 and the individual's privilege described in

1 sub-paragraph (1) above do not apply in the  
2 following situations:

3 (a) In any action by an individual  
4 pursuant to Section 8<sup>"</sup>(E) of this Act.

5 (b) In any proceeding where an individual  
6 introduces his physical or mental condition  
7 as an element of his claim or defense, including  
8 but not limited to tort or workmen's compen-  
9 sation actions, suits for disability benefits,  
10 or any suit brought by an individual against  
11 his physician including but not limited to  
12 any professional liability proceeding, or in  
13 any criminal or license revocation proceeding  
14 against a physician in which the individual  
15 is a complaining witness.

16 (c) In any proceeding before the court  
17 where the individual's physical or mental  
18 condition is relevant regarding the execution  
19 or witnessing of a will or other legal  
20 document by such individual.

21 (d) In any proceeding after the individual's  
22 death when his physical or mental condition  
23 is introduced by any party claiming or defending  
24 through or as a beneficiary of such individual.

25 (e) In a civil or criminal commitment  
26 proceeding, when a physician, in the course  
27 of diagnosis, treatment, or medical evaluation

1 of an individual, determines that such  
2 individual is in need of care and treatment  
3 in a hospital or any other health care  
4 facility which is deemed by the individual's  
5 physician to be appropriate for mental  
6 illness.

7 (f) If a judge finds that the individual,  
8 after having been informed that the communicatio  
9 would not be privileged, has made communications  
10 to a psychiatrist in the course of a psychiatric  
11 examination ordered by the court, provided  
12 that such communications shall be admissible  
13 only on issues involving the individual's  
14 mental condition.

15 (g) In any proceeding where it is  
16 demonstrated on a prima facie basis to the  
17 court that the individual's physical or mental  
18 condition is of an imminent and serious danger  
19 to the physical or mental health of another  
20 person, or to the security of the United States.

21 (h) The exceptions contained in items (a)  
22 through (g) of this sub-paragraph (2) are  
23 not intended to preclude the exemption of  
24 confidential medical information from com-  
25 pulsory court process or the individual's  
26 privilege described in sub-paragraph (1)  
27 hereof in any action brought or defended under

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1           the Divorce Act of this State unless the  
2           individual or witness on his behalf first  
3           testifies as to such confidential medical  
4           information.

5           PEER REVIEW PROCEEDINGS

6           Section 7. (a) Notwithstanding other provisions  
7           of this Act, physicians, hospitals and others may make  
8           confidential medical information of an individual  
9           available to medical peer review committees without  
10          his authorization.

11          (b) Confidential medical information before a  
12          medical peer review committee shall remain strictly  
13          confidential, and any person found guilty of the  
14          unlawful disclosure of such information shall be subject  
15          to the penalties provided in this Act.

16          (c) The proceedings and records of medical peer  
17          review committees shall not be subject to discovery or  
18          introduction into evidence in any proceeding against  
19          a physician or other provider of health services arising  
20          out of the matters which are the subject of evaluation  
21          and review by such committee and no person who was in  
22          attendance at a meeting of such committee shall be per-  
23          mitted or required to testify in any such proceeding  
24          as to any evidence or other matters produced or presented  
25          during the proceedings of such committee or as to any  
26          findings, recommendations, evaluations, opinions or

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1 other actions of such committee or any members thereof;  
2 provided, however, that information, documents or record  
3 otherwise discoverable or admissible in accordance with  
4 the other provisions of this Act from original sources  
5 are not to be construed as immune from discovery or use  
6 in any proceeding merely because they were presented  
7 during proceedings before such committee, nor is a  
8 member of such committee or other person appearing before  
9 it to be prevented from testifying as to matters within  
10 his knowledge and in accordance with the other provisions  
11 of this Act, but the said witness cannot be questioned  
12 about his testimony or other proceedings before such  
13 committee or opinions formed by him as a result of said  
14 committee hearing. The provisions of this sub-paragraph  
15 limiting discovery or testimony do not apply in any  
16 legal action brought by a medical peer review committee  
17 to restrict or revoke a physician's hospital staff  
18 privileges, or his license to practice medicine, or to  
19 cases where a member of the medical peer review committee  
20 or the legal entity which formed such committee or within  
21 which such committee operates is sued for actions taken  
22 which are alleged to have been malicious or not based  
23 upon reasonable belief that the facts warrant such  
24 action or that a reasonable effort to ascertain the  
25 facts has not been made.

26 (d) No member of a medical peer review committee  
27 nor the legal entity which formed such committee or

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1 within which such committee operates nor any person  
2 testifying before such committee shall be criminally  
3 or civilly liable for the performance of any duty,  
4 function or activity of such committee or based upon  
5 the testimony given before it or based upon any other  
6 way of having cooperated with it; provided that such  
7 action is without malice and based upon a reasonable  
8 belief that such action is warranted by the facts known  
9 to the individual or the committee after reasonable  
10 efforts to ascertain the facts has been made.

11 (e) In any legal action pursuant to sub-paragraph  
12 (c) or (d) above, a medical peer review committee shall  
13 not release those portions of an individual's confidential  
14 medical information from which the individual can be  
15 identified, unless specifically ordered by the court  
15 to do so.

17 PENALTIES

18 Section 8. (a) - Civil Penalties - (1) Any person  
19 or other entity who violates any provision of this Act  
20 is liable to any individual for general and punitive  
21 damages for violation of this Act without any showing  
22 of proof of special or actual damages. (2) Malicious  
23 or willful violation of this Act shall entitle an  
24 individual to treble actual damages and to punitive  
25 damages.

26 (b) - Criminal Penalties - (1) Any person or other

1 entity not authorized to obtain confidential medical  
2 information of an individual who fraudulently obtains  
3 such information shall be fined not less than \$500  
4 nor more than \$5,000 or imprisoned not less than 30  
5 days nor more than one year, or both. (2) Any person  
6 or other entity possessing an individual's confidential  
7 medical information, who knowingly and willfully and  
8 unlawfully provides such information to another person  
9 or other entity not authorized to receive such infor-  
10 mation shall be fined not less than \$500 nor more than  
11 \$5,000, or imprisoned for not less than 30 days nor  
12 more than one year, or both.

#### 13 CLASS ACTIONS

14 Section 9. Any individual entitled to bring  
15 an action under this Act may, if the alleged violation  
16 has caused or may cause damage to other individuals  
17 similarly situated, bring an action on behalf of him-  
18 self and such other individuals to recover damages or  
19 for other appropriate relief provided herein.

#### 20 INJUNCTIVE RELIEF

21 Section 10. Any person or other entity who violates  
22 this Act may be enjoined by any court of competent  
23 jurisdiction. Injunctive actions under this sub-section  
24 may be instituted by the Attorney General or any district  
25 attorney in this State in the name of the people of the  
26 State of \_\_\_\_\_ upon their own complaint or upon

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1 the complaint of any person  
2 or other entity, or by any person or other entity  
3 acting in his or its own behalf.

4 RIGHT OF COURT ACTION FOR  
5 AMENDMENT OR EXPUNGEMENT OF  
6 CONFIDENTIAL MEDICAL INFORMATION  
7 IN THIRD PARTIES POSSESSION

8 Section 11. An individual shall have the right  
9 to seek through court action the amendment or expungement  
10 of any part of his confidential medical information in  
11 a third party's possession which he believes is  
12 erroneous or no longer relevant.

13 VENUE

14 Section 12. Any action brought pursuant to this  
15 Act may be filed in the county in which the person  
16 alleging damage or seeking relief resides, or in the  
17 county in which the defendant resides, has his principal  
18 place of business, or is doing business.

19 ATTORNEY'S FEES

20 Section 13. In the case of any successful action  
21 for violation of this Act, the defendant shall be liable  
22 for the costs of the action together with reasonable  
23 attorney's fees as determined by the court.

24 WAIVER

25 Section 14. Any agreement purporting to waive

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1 the provisions of this Act is hereby declared to be  
2 against public policy and void.

3 SEVERABILITY

4 Section 15. If any provision of this Act is held  
5 by a court to be invalid, such invalidity shall not  
6 affect the remaining provisions of this Act, and to  
7 this end the provisions of this Act are hereby declared  
8 severable.

9 EXISTING LAWS IN CONFLICT WITH THIS ACT

10 Section 16. With the exception that no provision  
11 of this Act shall be construed to make confidential any  
12 record maintained by any local, state, or federal entity  
13 which by law is not confidential or to require disclosure  
14 of any public record which by law is confidential, all  
15 laws or parts of laws in conflict herewith are hereby  
16 repealed.

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X. RELEASE OF INFORMATION FROM HOSPITAL MEDICAL RECORDS  
(RESOLUTIONS 34 AND 37, C-71)  
(Reference Committee D, page 321)

HOUSE ACTION: ADOPTED AND IN LIEU OF RESOLUTION 114

Resolutions 34 and 37 (C-71) were referred by the House to the Board of Trustees with the request that a report be submitted to the House of Delegates at the 1972 Annual Convention. Resolution 34 sets forth specific guidelines to govern the release of medical information from hospital medical record departments for implementation by the medical record committee of each hospital medical staff. Resolution 37 requests changes in Medical Record Services Standard III by the Joint Commission on Accreditation of Hospitals to reflect the guidelines in Resolution 34.

Following careful study of Resolutions 34 and 37, the Board recommends that national guidelines governing the release of information from hospital medical records not be established. Policies or guidelines governing the release of information from hospital medical records must be based upon applicable state laws and regulations, judicial rulings, local custom and other factors. Such policies can be promulgated at the state level by medical and hospital associations, singly or cooperatively, with the advice and consultation of attorneys familiar with the applicable state laws, regulations and court decisions. The experience of the hospitals in a given locale can be taken into consideration also. Using this method, policy statements or guidelines can be promulgated that will adequately protect the legitimate interests of the hospital, the patient, medical staff members and third parties in the medical information contained in hospital medical records. Support for this recommendation is based on the following informational report:

RESOLUTION 34 (C-71)

Resolution 34 seeks to have the Medical Records Committee of the hospital medical staff establish and enforce the following guidelines to govern the release of medical information from patient records:

1. All requests for medical information must be accompanied by a properly executed, current authorization signed by an informed patient or his proper representative;

2. Only identification data, admission and final diagnosis, and the name of any surgical procedure performed with the verified pathological diagnosis can be released;
3. Requests for additional information are to be referred to the attending physician;
4. Requests for the entire medical record or photostatic copies of the history, physical examination and progress notes are to be considered unethical and unacceptable;
5. Requests that call for antecedent information pertinent to insurance contestability clauses are referred for a review of the medical records by the attending physician and shall not require submission of operative reports or tissue reports, x-ray reports or reports of laboratory procedures;
6. For purposes of government provider audit programs, the auditor may be shown the record of the physician's authorization, but not nurses' notes, progress notes or diagnostic data;
7. An attending physician may honor requests for unusual information of a technical nature which is not covered in 2.; and
8. Required certification and recertification statements are not to be included in progress notes, but filed separately from the patient records and made available to the carrier or government agency.

#### RESOLUTION 37 (C-71)

Resolution 37 directs the AMA to request the Joint Commission on Accreditation of Hospitals to change the interpretation of Standard III for Medical Records Services to specify: (1) that the written consent of the patient for release of medical information from his hospital record shall be obtained after the record is created and shall be applicable only to the face sheet summary of the record; (2) that entire records or copies of entire records may be removed from the hospital safekeeping only in accordance with a court order, subpoena or statute; (3) that in the event that hospital records are subpoenaed, the hospital should send the records directly to the court that issued the order and not through a third party or an attorney; (4) that in the case of records of psychiatric patients, extraordinary precaution such as separate, locked files, may be required to preserve the privacy of some portions; and (5) that third parties should obtain any necessary additional information directly from the attending physician.

Although the resolution calls for the promulgation of guidelines to limit or restrict the kinds of information that may be released from hospital medical records because of what are considered to be excessive demands by hospital service corporations and agents of the federal government, the guidelines would be applicable to requests from all sources. Requests from any agent of the patient, from other hospitals or from physicians for medical information contained in hospital records would be treated in the same manner.



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The Reference Committees to which these two resolutions were referred recognized "numerous legal implications" and so recommended referral to the Board of Trustees for study prior to reporting to the House of Delegates. Following is a discussion of some of the legal considerations and implications.

#### HOSPITAL MEDICAL RECORDS

A hospital medical record is the complete, written record of the pertinent information on a patient's past and present medical history, his condition and treatment and the results of hospitalization. The record consists of reports made by the various departments, such as radiology, pathology and surgery, the opinions of consultants, progress notes entered by the attending physician, and observations of house staff and nurses. The minimum essential information recorded includes: (1) identification data; (2) medical history; (3) report of the physical examination; (4) diagnostic and therapeutic orders; (5) observations; (6) reports of diagnostic and therapeutic procedures; and (7) conclusions.

The significant clinical information pertaining to the course of hospitalization is entered contemporaneously with its occurrence in a properly compiled hospital record. This method of compilation gives a hospital medical record particular legal significance and importance.

The primary purpose of a hospital medical record is to aid and assure continuity of patient care. The record also provides a means of communication between the attending physician and any professionals who contribute to the patient's care; furnishes the documentary evidence of the course of the patient's illness and treatment during each hospital stay; serves as the basis for review, study and evaluation of the care provided to the individual patient and the general standards of patient care maintained in a particular hospital; assists in protecting the legal interests of patients, hospitals and responsible practitioners; and serves as a valuable source of data for use in research and education.

#### LEGAL REQUIREMENTS

Medical records have become an integral and essential part of hospital care since they contain all of the data considered necessary for the treatment of patients. As a consequence, the form, substance and accuracy of the hospital medical record is regulated increasingly by state agencies, governmental and nongovernmental bodies.

State hospital licensing acts require hospitals to maintain accurate, complete medical records. These acts are not uniform, but all of them give lenary power to the responsible agency to promulgate rules and regulations for hospitals and these regulations establish minimum record requirements. Some detail the information that must be included, others specify only broad areas of information for inclusion and some state simply that the records must be accurate and complete. A number of the regulations contain specific provisions relating to the time within which medical records must be completed, the period of time they must be retained and what entries must be signed by the responsible physician.

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The Joint Commission on Accreditation of Hospitals also establishes standards for hospital medical records with which institutions comply voluntarily in order to seek or retain an accredited status. The standards specify the information that must be included. The Medicare and Medicaid regulations require compliance with the state hospital licensing regulations and contain detailed requirements for medical records in addition.

#### OWNERSHIP AND CONTROL OF THE MEDICAL RECORD

The law in this country is well established that the original hospital records are the property of the hospital, just as medical records maintained in a physician's office are the property of the physician. Hospital and physician medical records are a unique form of property, however, and the law recognizes other interests in these records. The patient has a recognized right to information from the records, at least to the extent that the information is necessary for the protection of his health interests or his legal rights. Physicians also have recognized interests in hospital records to the extent that access to the records of a patient is necessary for the protection of the health interests of the patient. The law does not recognize or give a physician any right to prevent a hospital from making a lawful disclosure of information in the hospital records of his patients, however.

The property rights of the hospital in medical records impose a duty of custodial care on the hospital. In other words, the hospital has a duty not only to protect the confidentiality of the information contained in such records from misuse by hospital personnel or others who have or seek access to it, but to determine who may have access to this information and under what circumstances. The hospital is responsible for making certain that there is no tampering with the medical records, that they are maintained in a complete and accurate manner and that the information contained in the records is filed and indexed in such manner as to be useful.

#### CONFIDENTIAL COMMUNICATIONS

A physician has an ethical duty to keep secret information about his patient that is obtained in the course of his professional employment. Section 7 of the Principles of Medical Ethics states: "A physician may not reveal the confidence entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients unless required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community."

This ethical precept has been recognized and is reflected in the code of ethics of the hospital associations, associations of health insurance carriers and other corporations and agencies that handle medical information. Protecting the confidentiality of the personal and medical information in hospital medical records is considered necessary to protect patients from humiliation, embarrassment or discomfort.

#### DISCLOSURE OF INFORMATION FROM MEDICAL RECORDS

Until thirty years ago, hospitals were reluctant to release information from patient medical records. This attitude undoubtedly was based upon the

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application of medical ethics to a relatively simple situation. In most cases, the only persons who had a legitimate interest in the patient's records were the hospital and physicians. The ethical precept that assures patients the benefit of protection of confidential information has not changed, but the factual situation today is far different.

The increasing incidence of personal injury litigation and the expanding use of life, accident and health insurance are major factors which operate to multiply the number of persons who have a legitimate interest in hospital medical records. More than 187 million Americans are covered by hospital service or insurance contracts of one form or another. The questions more frequently raised are whether a hospital today can deny access to patient records by authorized agents or disclose information in the records to third parties without the patient's consent.

This is one area of the law that is not settled in all jurisdiction. In the few states in which a patient has sought the help of a court in order to examine the contents of his hospital record, the decisions have upheld his right. Courts have also upheld the rights of insurance companies to inspect the records of policyholders in order to determine whether claims under their policies must be paid. The courts in these jurisdictions have stated that when records are required to be kept by force of statute, such as the hospital licensing laws and regulations, they become quasi-public. Quasi-public documents are made available for inspection by persons with legitimate interests with few exceptions and such inspection can be limited only by reasonable restrictions.

Social recognition of needed freedom to use hospital records for legitimate purposes is also evidenced by the fact that twenty-four states have enacted statutes to permit the use of such records for morbidity and mortality studies and other forms of research that will benefit society as a whole provided the identity of individual patients is protected. Connecticut, Illinois, Massachusetts and Wisconsin by statute require licensed hospitals or hospitals receiving state funds to permit examination and copying of medical records by patients or their authorized representatives. In at least twenty states, hospital lien laws permit persons or corporations responsible for an injury to inspect hospital records relating to that injury without a patient's consent. California by statute permits an attorney who is considering filing an action to examine or copy a patient's records on his signed authorization. Some of these statutes do include specific protection for records maintained by hospitals specializing in mental illness.

The hospital licensure statutes in Kansas, Pennsylvania, North Carolina and South Carolina state that patient records must not be taken from the hospital except under court order. Even in these states and in others that have provisions in the hospital licensing act declaring that hospital medical records are not public records, this has been interpreted by the courts to mean that they are not open to public inspection, but is not intended to preclude inspection by those persons who have a legitimate interest in the contents or inspection authorized by the patient himself.

The conclusion that can be drawn from the reported decisions involving attempts to gain access to or use the information in hospital medical records

is that hospitals rarely have a reason to deny inspection authorized by a patient or requested by a person having a legitimate interest in such information on a patient's behalf. Even without a patient's implied or express authorization, it is doubtful if a hospital would incur liability should information from a patient's medical records be disclosed without malice to any of the following interested persons: hospital personnel; third parties directly concerned with payment of the patient's bill; personnel of the industrial accident commission; a patient's attorney; an attending physician; a physician who has a professional or academic interest in the type of case; law enforcement agencies; military authorities when the patient is a serviceman; and civilian agencies of government whenever the patient's case is of legitimate concern to them.

#### PATIENTS' RIGHTS

Confidentiality with respect to hospital medical records is a right of the patient, not the physician, nor the hospital. Both the physician and the hospital must respect not only the patient's right to confidentiality regarding medical records concerned with his care and treatment in the hospital but also must respect the patient's authorization to provide the medical record to those whom the patient authorizes to inspect it. Expressly or impliedly, every patient has authorized the release of medical records to such third party payers as may have legal liability for the payment of any part of the charges for the medical care and treatment provided to the patient in the hospital. The source of such legal liability may be either a private contract purchased by the patient, or legislation under which the patient may claim benefits.

If the source of the third party payer's legal liability for payment of the patient's hospital and medical bills is contractual, the patient has agreed to provide such medical records as the third party may require, as one of the conditions of receiving the benefits under the contract. The patient having so bargained with respect to his right of confidentiality, it would be inappropriate for the hospital, as the owner of the medical records, to limit the information which the patient has agreed to release. The third party payer has bargained with the patient for such information as it needs, not only to verify its responsibility under the contract, and the extent thereof, but also to permit it to structure its contract terms with other prospective patients. Reference to the "contestability clause" in the contract between the third party payer and the patient is only one of the many areas of concern for which the parties to the contract have agreed to make medical records available. The patient's interest would not be served by attempting to limit the release of information for which the patient has already authorized release in full.

#### MEDICARE AND MEDICAID PROGRAMS

As a condition of participation under the Medicare law, a hospital must maintain medical records for every patient given care in the hospital. These records must be maintained in accordance with accepted professional standards, and written consent of the beneficiary must be required as authority for the release of medical information from the records (Reg. Sec. 405.1026). As a condition of payment to a participating hospital the beneficiary or his representative must sign a request for payment which contains the following language:

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"I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf."

The beneficiary may also check an additional box on the form to indicate that the authorization for the release of needed medical or other information should apply to insurance carriers providing supplementary coverage or to welfare agencies.

Additionally, the Medicare patient's physician must certify that the treatment provided was medically necessary and the services provided were medically required. Finally, there must be compliance with an approved plan of utilization review in the hospital (Reg. Secs. 405.160, 405.162, 405.163 and 405.1035). All of these conditions require reference to the beneficiary's medical records for substantiation. The Medicare law provides that a hospital's right to be a participating provider may be terminated by the Secretary of Health, Education, and Welfare under the following circumstances, among others:

"that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information." (Sec. 1866 (b)(2)(c))

Information so provided is protected by strict requirements under the law against disclosure for other than proper program purposes and severe penalties are provided for violations of these restrictions (Sec. 1106).

All hospital costs applicable to Medicare are subject to audit and final retroactive adjustment in a hospital's costs for any reporting period will not be made until the hospital's cost report has been audited. The intermediary will determine the scope of the audit, but medical records must be available to the auditor if requested.

Provider Relations Bulletin No. 74 (February 28, 1968) contains a concise explanation of the purpose of an auditor's review of medical records. It states in part:

"The audit is designed to review the system of internal control over the processing of transactions within a hospital. The financial transaction starts with a physician's order in the medical record. It is the only source of authorization for services ordered by the physician and therefore it is necessary for the auditor to review the orders of the physician to ascertain that the charge for services rendered corresponds with the physician's orders. The auditor must trace the order for services to the department rendering the service in order to verify that the service was actually rendered, and then, he must trace the charge to the patient's ledger. It is



essential that the auditor verify that all services rendered are recorded in the medical records to avoid a distortion of the method of reimbursement."

In order to participate under the Title XIX (Medicaid) program in its state, a hospital must agree to maintain such records as will fully disclose the extent of services provided to individuals receiving such assistance, and must further agree to furnish the state agency with such information as the state agency may require concerning services provided to any individual receiving benefits under the program (Sec. 1902 (a)(27) and Reg. Sec. 250.21). The State's Titled XIX Plan requires the state agency to provide standards and methods to "assure that medical or remedial care and services provided to recipients of medical assistance are of high quality" (Sec. 1902(a)(22)(D)) and provide safeguards against unnecessary utilization of medical care and services (Sec. 1902(a)(30)).

Furthermore, the state must provide a regular program of "professional review" including a medical evaluation of each patient's need for hospital care and periodic on-site inspections of hospitals to include a review of the adequacy of the care and services rendered to recipients of such assistance (Sec. 1902(a)(31)).

In turn, the state agency is required to report to the Secretary of Health, Education, and Welfare and be able to substantiate the accuracy of such reports. (Sec. 1902(a)(6)).

The Act and the regulations thereunder require that a State Statute which imposes legal sanctions will safeguard and limit the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the program (Sec. 1902(a)(7) and Reg. Sec. 205.50). An individual who has received medical assistance benefits under the program must be deemed to have waived his rights of confidentiality and to have impliedly consented to the release of his medical records in connection with the care and treatment provided to him. However, his expressed authorization to release his medical records is invariably provided for before or at the time the services are rendered.

#### ROLE OF THE MEDICAL RECORDS COMMITTEE

The Medical Records Committee of the medical staff is responsible for reviewing all of the medical records compiled at the hospital to make certain that they meet the highest possible standard of patient care usefulness and historical validity. Because hospital medical records constitute important evidentiary material and can be reached for pretrial discovery purposes in all jurisdictions, there is a tendency to view them primarily as legal documents. The primary purpose of the hospital medical record is to aid patient care and not to provide a record for use in litigation. The legal aspects of medical records therefore should be viewed in proper perspective as subordinate to the medical purpose of the record. The Medical Records Committee should keep this in mind at all times in developing policies and reporting to the medical staff.

The Medical Records Committee functions are dual in the sense that this committee performs an essential educational service in addition to its review



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functions. Through the review, evaluation and subsequent recommendations of this Committee can come improvements in the form and format of medical records. The entries should be factual for the most part, pertinent to the patient's condition and treatment and free from opinions and observations that have no relevance to the course of hospitalization. Comments on the adequacy of the nursing care, details of intimate family problems, opinions on the personality flaws of patients serve no purpose in the usual hospital medical record. The record should document the facts of the hospitalization and the Medical Records Committee should make certain that all records in the permanent files comply with its policies and recommendations in this regard.

In addition to the review and evaluation of the adequacy and completeness of the medical records within the hospital, the Medical Records Committee with the aid of legal counsel is also responsible for developing the hospital policy that governs the release or examination of information in the hospital medical records. In determining this policy, the legal requirements and precedents in the particular jurisdiction must be kept in mind. As a general rule, the hospital policy should require patient authorization before any request is honored may restrict inspection to regular business hours; may require hospital personnel to be present during inspection or examination; and may contain a provision that requests by attorneys in addition to being accompanied by the patient's authorization shall be evaluated individually.

The hospital policy developed by the Committee should also include provisions governing the circumstances when notice and prior approval of an attending physician will be required before an authorized request will be honored. In those jurisdictions where the law is settled, notice to and approval by the attending physician may not be considered a necessary requirement when the request is submitted by a third-party source of payment, by a governmental agency a public health official, or in work-related injury cases. The Medical Records Committee may wish to recommend the use of an authorization form that includes these cases on the regular hospital admission form if this policy is adopted by the medical staff. In cases where prior approval by an attending physician for the release of information is necessary to protect his interests, such as requests from attorneys or investigators, provision for notification and obtaining the attending physician's permission should be included in the hospital policy. The hospital policy should also include the conditions of disclosure to non-attending physicians engaged in research. Protection of the identity of the patient is important when records are used for research or educational purposes, even where statutes provide immunity for the hospital's release of information for this purpose. The objectives of the study for which information from the medical records is sought should be evaluated and a provision to this effect can be included.

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# Citizens Bill of Hospital Rights

What the Patient and Public Can and Should  
Expect from Our Hospitals

by Herbert S. Denenberg  
Pennsylvania Insurance Commissioner



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PENNSYLVANIA INSURANCE DEPARTMENT  
Harrisburg, Pennsylvania, 17120  
April 1973

HERBERT S. DENENBERG  
INSURANCE COMMISSIONER

MILTON J. SHAPP  
GOVERNOR

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# *Citizens Bill of Hospital Rights*

Patients have rights in a hospital but often are not aware of them. So we have stated here what we believe are the basic rights of the patient while in a hospital.

Other groups have issued their own "Patient's Bill of Rights" in recent months; two such groups are the American Hospital Association and Beth Israel Hospital in Boston. We have issued our own version because we believe the others, however well intentioned, do not go far enough.

For instance, the American Hospital Association in its 14-point list, granted patients the right to considerate care, confidential care, and continuous care among others. This Association's list may include useful and important advances, but it omits some of the most basic rights. What patients need and must have a right to is competent and quality care at prices they can afford. It may be that the American Hospital Association did not want to promise what it couldn't deliver but it should deliver a lot more than it has promised. Furthermore, we believe a Bill of Rights should help point out the problems we have to solve, and exert pressure for their solution.

In addition to correcting the glaring omissions of these other bills of rights, we have taken a somewhat broader view of the entire issue. We believe that you have rights regarding hospitals whether you're a patient or not. Every member of the public pays for hospitals through his health insurance, his Blue Cross and Blue Shield premiums, and his tax dollars. So the bill of rights should apply to all citizens—to all members of the public—not just patients.

We think a bill of rights should be more than words and rhetoric, and so we have formulated rights which are based on law or are otherwise enforceable through procedures which the public has access to. If these rights are not already recognized, there are private and public agencies that can demand their recognition. For example, if a hospital does not recognize these rights, we think Blue Cross should refuse to enter into contracts with it. In some cases, a person denied his rights as a patient may actually enforce his rights by a lawsuit or the aid of the appropriate private or government agency.

Most hospitals are community hospitals and are supposed to be run by and for the benefit of the public. Generally, hospitals are licensed by

our states. So the public ought to start asserting its existing rights and developing new ones. And the public should start insisting that hospitals grant their patients and the public the rights which should be legally and morally forthcoming.

The hospitals have not delivered in the public interest, so it's time for the public to make sure they do.

We think this Bill of Rights is especially significant not only because of its substance but also because of its source. It is the first "Hospital Bill of Rights" formulated by a government agency. We intend to use the regulatory power of the Pennsylvania Insurance Department to enforce this Bill of Rights. (The Department has authority over contracts between Blue Cross and the hospitals and between Blue Shield and the doctors. It also regulates insurance policy forms and certain health insurance premiums.) We also intend to enlist the aid of the other branches of state government in seeing to it that the rights stated here are recognized in full by the hospitals.

Historically, the physician has been seen as the friend of the patient, with the hospital the haven and sanctuary of the patient. But in recent years, the patient has come to view the medical-hospital establishment as the "enemy", and the hospital as the haven and sanctuary of the doctor, not the patient. It is hoped that the recognition of the rights which follow will create the relationship of confidence, friendship, and trust that should exist and that will promote the interests of all parties.

## 1. Quality of Care

The public has a right to good quality care and high professional standards that are continuously monitored and reviewed. This includes frank disclosure to the patient when it is discovered that poor quality care has been delivered or when there has been medical or hospital malpractice.

No one can expect perfection. However, the public has a right to expect a system which continuously strives to deliver high quality care with a minimum of errors. The public isn't getting anything close to that.

## 2. Economy of Care

The public has a right to economical care and to hospital management that operates efficiently and eliminates waste, such as unnecessary services and duplicative and unsafe facilities.

When the public can't afford the care it needs, it is tragic to squander about \$25 billion a year because of wasteful practices of a health delivery system.

Most people don't have adequate health insurance coverage now, but they still have to pay about \$40 or more a month just for the limited protection now available. The average consumer pays too much and gets too little for the health insurance he now carries, so there is no room for needless waste that is all too characteristic of our present system.

Hospitals often try to justify waste by pious pronouncements about the quality of care. Available evidence suggests, however, that the prudent use of resources raises the quality of care rather than lowers it. For example, if too many hospitals do open heart surgery, costs are excessive and the quality of the service rendered becomes substandard. Complicated medical procedures require skilled teams that know how to work together. Underutilized facilities breed doctors that are out of practice. So if we have needless duplication of facilities and services we are likely to throw away lives as well as dollars. When we eliminate such duplication, we improve the quality of medical care and save money at the same time. This kind of duplication exists in large and small communities, and in exotic as well as commonplace services and facilities.

### 3. Consumer Input and Participation in the Decision Process

The public has a right to have its voice heard in the management, control and planning of hospitals, and in the case of community hospitals it should be assured of a board of directors that represents a broad cross-section of the community. It has a right to see the end of present boards dominated by bankers, accountants, lawyers and heavy donors. It has a right to boards that can and do represent and serve the entire community.

This is not merely an idealistic hope for consumer control. Without consumer control, we are not likely to get the cost and quality controls that are essential for any viable health delivery system. Doctors, for example, take one view of unnecessary surgery; patient's quite another. Only when we have a health care delivery system run for the benefit of the public will we get the right decisions. When we have a system run for the benefit of physicians and hospitals, we get what we now have.

#### 4. Access to Information and Answers About Treatment

The patient has a right to full information on his diagnosis, treatment, and prognosis in terms he can understand. This should include information about alternative treatments and possible complications. The patient is entitled to have his questions answered on any phase of his hospital and medical care.

He is entitled to this information from his doctors and hospital staff and should be given it willingly and enthusiastically. The patient should not feel he is imposing when he asks a question, seeks an explanation, or asks for other information.

The patient is entitled to know the names of his doctors, including the doctor coordinating his case, and everyone responsible for his care.

The hospital should make it easy for patients to know who they are dealing with. Every member of the hospital staff should wear a name tag with his full name and job title. Patients should not have to guess whether the man in the white coat is a doctor, waiter, orderly, or uninvited visitor.

The American Hospital Association noted in its Bill of Rights that there may be circumstances when it is not medically advisable to give such information to the patient. We agree. The primary purpose of a hospital is make sick people well and these rights are not intended to conflict with that goal in the slightest degree.

The American Hospital Association Bill of Rights states: "When it is not medically advisable to give such information to the patient, the information should be available to an appropriate person on his behalf."

Inadequate disclosure of information or arbitrary denial of the right to information regarding your treatment may lead directly to a court case. The "Shopper's Guide to Surgery", published earlier by the Pennsylvania Insurance Department, states: "Under the legal doctrine of informed consent, a patient who has not been fairly advised about the risks of surgery has not legally consented to it. He may, therefore, sue any doctor for malpractice who operates on him without fairly disclosing the risks incurred."

The patient need not exercise his right to know. Some patients prefer "not to be told" and they have every right to the sweet bliss of ignorance.

Hospital forms and documents are often indecipherable. They should be rewritten in simple language that a patient can understand.



For example, the consent forms signed before surgery are worthy products of the legal mind, but no tribute to those that admire language that can be understood.

The public should insist that these and other hospital forms be revised immediately. There are now methods to objectively judge the readability of all hospital documents.

The Pennsylvania Insurance Department, for the first time in insurance regulatory history, is now applying readability standards to insurance policies. Using a scientific formula developed by Rudolph Flesch, the Pennsylvania Insurance Department is now able to measure the readability of each policy on a scale running from 100 on down. Many policies are actually less readable than Einstein's basic work on relativity. Many hospital forms are in the same class.

Patients should protest when asked to sign forms that are not readable. The hospitals would soon get the message.

## 5. Personal Dignity

The patient has a right to personal dignity at all times. Among others, this includes the right to be treated without discrimination based on race, color, religion, national origin, ability to pay or source of payment; the right to considerate and respectful care; and the right to privacy and confidentiality of personal records. Those not directly involved in the treatment should affirmatively disclose their purposes and obtain permission of the patient to be present.

This patient has a right to be accorded the same respect always given doctors in hospitals but rarely accorded patients.

The Bill of Rights issued by the Beth Israel Hospital spoke to this point. "The right to be treated respectfully by others; to be addressed by your proper name and without undue familiarity; to be listened to when you have a question or desire more information and to receive a helpful and appropriate response."

To make the right to privacy meaningful, hospitals are going to have to take another look at their current design and construction. For example, Barbara Fisher Perry states in her book, *Care Without Care*, on p. 214: "Hospital facilities must be redesigned so that even outpatient and emergency departments allow for separate examining areas for male and female patients." Of course, there has to be a reasonable compromise between perfect privacy and the realities of the cost of hospital facilities.

The right to privacy includes the right to exclude from the hospital room and the examination room anyone not directly involved in care, such as students being educated on the job in the hospital. This right should not be exercised too frequently, as we all benefit from an effective education system for health delivery personnel.

But we agree with the American Hospital Association that, "Those not directly involved in the patient's care must have the permission of the patient to be present."

Hospitals, even when they are compelled to turn over records by the force of a subpoena to some third person, should immediately notify the patient.

Third-party payers, such as Blue Cross and Blue Shield, and others involved in monitoring the health delivery system need access to medical records to do their job. The right to privacy of the patient should be protected by those who carry out this payment and monitoring function.

#### **6. Control of One's Body and Life**

The patient has the right to control his body and life. This includes the patient's right to refuse treatment to the extent permitted by law, to be informed of the medical consequences of his action, and to leave the hospital when he desires to do so.

The American Hospital Association's Bill of Rights said: "The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has a right to refuse to participate in such research projects."

Beth Israel Hospital in Boston told its patients: "You have the right to leave the hospital even if your doctors advise against it, unless you have certain infectious diseases which may influence the health of others, or if you are incapable of maintaining your own safety, as defined by law. If you do decide to leave before the doctors advise, the hospital will not be responsible for any harm that this may cause you and you will be asked to sign a 'Discharge Against Advice Form'." More hospitals should tell their patients the same thing.

#### **7. Action on Complaints and Problems**

The patient has a right to redress of grievances in a reasonably efficient and timely fashion. This means the hospital should establish formal grievance procedures and appoint ombudsmen or patient advocates to be certain that problems are identified and remedied.

Complaints should be handled promptly and any indicated remedial action should be taken as soon as possible. The patient's complaint should be processed and he should not only get appropriate action but get the clear feeling the hospital is interested in his views and will do something about legitimate complaints.

Hospitals should also seek to establish new techniques of handling grievances. For example, the hospital should consider agreeing to arbitration for certain types of patient disputes.

Hospitals should let patients know about how to assert complaints. Forms for doing so should be readily available.

#### **8. Disclosure of Data About Hospital**

The public has a right to full information about the finances and activities of the hospital. This should include general information about assets, expenses, costs, profits, charges, occupancy and the like. This also includes information about the board of directors of the hospitals, physicians on the hospital staff, and all of its rules and regulations, including those which apply to his conduct as a patient. Finally, it includes information about financial aid available from the hospital.

This information should be voluntarily and automatically disclosed.

#### **9. Disclosure of Conflict of Interest Problems**

The patient and public has the right to full disclosure of any hospital relationships that pose an immediate or potential conflict of interest.

This means that every for-profit hospital should have strict procedures for enforcing the American Medical Association's ethical rule which is as follows: "When a physician has an interest in or owns a for-profit hospital to which he sends his patients, he has an affirmative ethical obligation to disclose this fact to his patient." This is only one possible hospital conflict of interest among many. For example, doctors may own outside laboratories, nursing homes, x-ray facilities and other health service facilities.

#### **10. Access to Information About Stay and Records of Case**

The patient has a right to full information about his stay, including information about his bill and access to his hospital records. This includes detailed information about his hospital bill, including itemized charges. This information should be readily available regardless of the patient's source of payment.

Hospital documents, as previously indicated, should be clear and readable. This applies to the bills rendered patients. Even the lawyer's "legalese" sometimes seems clear to the newly created puzzle of "computerese." The hospital bill, however efficient for internal accounting purposes, all too typically does not communicate its message to the patient. Hospitals should also attempt to keep the patient informed of his bill at reasonably frequent intervals.

#### 11. Continuity of Care

The patient has a right to continuity of care. This includes timely response to his needs and appropriate transfer to other facilities.

The American Hospital Association's Bill of Rights talks about reasonable continuity of care. It adds that the patient: "has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge."

That Bill of Rights also discusses another aspect of continuity of care: "When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer."

#### 12. Consumer Advocacy

The public has a right to expect a hospital to behave as a consumer advocate rather than as a business headquarters for doctors and hospital officials. The hospital should affirmatively and aggressively move to protect the patient and his interests rather than rubber-stamp the demands of doctors. The hospital should provide leadership in improving health care for the community.

Hospitals have often had only one idea for changing the health delivery system: Getting more money for the hospitals. The hospital is a repository of great know-how and expertise, and should use that know-how responsibly. It should come up with sound proposals for reform and aggressively advocate the consumer's interest.

A hospital can take "step one" toward consumer advocacy by adopting this bill of rights and making it known to all of the hospital's patients and to the community which it serves.

# Psychiatry in the Legal Process: "A Knife that Cuts Both Ways"

Alan M. Dershowitz

In the trial scene from *Brothers Karamozov*, Dostoyevsky, speaking through the lips of the defense attorney, issued a stern warning to the legal profession:

Profound as psychology is, it's a knife that cuts both ways. . . . You can prove anything by it. I am speaking of the abuse of psychology, gentlemen.

I will speak today about another knife that cuts two ways: psychiatry in the legal process. Much has been written about one cutting edge: the contributions made by psychiatry. I will focus on the other side of the blade: the social costs incurred by the increasing involvement of the psychiatrist in the administration of justice. An important—if subtle—consequence of psychiatric involvement has been the gradual introduction of a medical model in place of the laws' efforts to articulate legally relevant criteria. The cost of this substitution has been confusion of purpose, and in some instances, needless deprivation of liberty.

A brief look at the history of the insanity defense will serve to illustrate this process. The law had, for centuries, been groping for a rule which would express the deeply felt conviction that some people who commit condemnable acts are not themselves deserving of condemnation. In the 17th century, a person was held irresponsible if he "doth not know what he was doing, no more than an infant or a wild beast." There was an obvious relationship between this "wild beast" test and the rest of the criminal law: neither an infant nor a wild beast was held responsible; so why, it was asked, should an adult who was functionally similar. In the much villified *McNaghten* case, the House of Lords also analogized irresponsibility to a deeply rooted principle of the criminal law. It held that a man who suffers from delusions

must be considered in the same situation as to responsibility as if the facts with respect to which the delusion exists were real." This was a simple extension of the traditional mistake of fact defense to certain unreasonable mistakes. The Lords' attempt to generalize this principle under the rubric "know the nature and quality of the act," and know that it was "wrong," was surely not the clearest way of saying what they meant. But it *was* clear that they—like the framers of the "wild beast" test—were setting down a *legal* rule designed to further *legal* policies; they were not attempting to identify and exculpate a particular psychiatric category of persons—the mentally ill, the insane or the psychotic. Indeed, the ruling explicitly recognized the rather limited role of the psychiatrist in administering the insanity defense. Nevertheless, much of the criticism of *McNaghten* has been premised on the erroneous assumption that the purpose of that test *was* to describe a psychiatric entity. Thus, Dr. Isaac Ray, an early psychiatric critic, called the *McNaghten* rule a "fallacious" test of criminal responsibility, arguing that: "Insanity is a disease, and, as in the case with all other diseases, the fact of its existence is never established by a single diagnostic symptom"—such as inability to distinguish right from wrong. But the Lords had not focused on inability to distinguish right from wrong because they thought it was a scientifically valid symptom of disease; they focused on it because they deemed it a just and useful legal criterion for distinguishing those who should be held responsible and punished from those who should be held irresponsible and hospitalized. Now this criterion may be criticized as unjust or unworkable, but to say it is "fallacious" is to misunderstand the nature of legal rules. Ray was attempting to substitute a medical model of responsibility for the legal one; and the law was not engaging in a fallacy by insisting on

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ALAN M. DERSHOWITZ, a member of the District of Columbia bar, is a professor of law at Harvard University and a consultant to the National Institute of Mental Health.



asking its own questions and establishing criteria relevant to its own purposes.

This attempt to impose a medical model on the legal process of distinguishing the responsible from the irresponsible continued through the 19th century and into the 20th. It culminated in the case of *Durham v. United States*, decided in 1954. The argument for the *Durham* rule was simple—if one accepted Ray's erroneous premise. For if *McNaghten* was simply an attempt to identify those persons considered mentally ill by psychiatrists, then why bother to go through the indirection of listing symptoms? Why not make the test the existence of mental illness itself? Abe Fortas, counsel for *Durham* and now Justice Fortas, argued that substitution of a new rule for *McNaghten* would permit psychiatrists to testify in "the terms of their own discipline, and not in the terminology of an irrelevant formula." Why the "right-wrong" formula was irrelevant for legal purposes the court was never told, except that it did not permit psychiatrists to testify in terms of their own discipline. The possibility that the terms of their own discipline are not particularly relevant to a perfectly rational legal rule was never considered. The court was simply urged to adopt the psychiatrists' medical model of "insanity" and abandon any efforts of its own to articulate legally functional rules. The United States Court of Appeals for the District of Columbia accepted Fortas' arguments and adopted a rule framed in medical terms: "an accused is not responsible if his unlawful act was the product of a mental disease or defect." Although the author of *Durham*, Judge Bazelon, has always regarded that case as merely an opening wedge in a continuing search for just and workable criteria of responsibility, many psychiatrists interpreted *Durham* as an invitation for them to decide who should and who should not be held criminally responsible. Indeed, in

one famous episode, the staff of a large mental hospital apparently took a vote to determine whether or not sociopathic personality was to be regarded as a mental disease. The issue of criminal responsibility was finally where Isaac Ray thought it belonged: in the therapeutic hands of the psychiatrist.

This then is a capsule history of one encounter between law and psychiatry. It is not a complete history. There have been judicial adumbrations of disillusionment with the medical model. But it is a discouraging history of usurpation and abdication: of an expert being summoned for a limited purpose, assuming his own indispensability, and then persuading the law to ask the critical questions in terms which make him more comfortable and his testimony more relevant. The upshot has been to make the psychiatrist's testimony more relevant to the questions posed, but to make the questions themselves less relevant to the purpose of the law.

This history has been repeated in other areas of the law, less well known than the insanity defense. Let me now turn to one in which psychiatric involvement has incurred even higher social costs—costs measured in years of needless and unjustified deprivation of liberty. I speak of the process known as civil commitment of the mentally ill, whereby almost one million persons are today confined behind the locked doors of state mental hospitals, though never convicted of crime.

Not in every society and not in every age were the insane confined by the state. The building of asylums on a wide scale did not begin until the 17th century. Such confinement—like the defense of insanity—was originally designed to further vaguely articulated legal goals. In the 18th and early 19th century these laws were part of a larger tapestry which included "suppression of rogues, vagabonds, common beggars and other idle, disorderly



and lewd persons." The legislative purpose seems clear: to isolate those persons who—for whatever reason—were regarded as intolerably obnoxious to the community. Medical testimony had little to offer in making this judgment: the people knew whom they regarded as obnoxious. By the middle of the 19th century—again through the influence of Dr. Isaac Ray—madness was becoming widely regarded as a disease which should be treated by physicians with little, or no, interference by courts. The present situation comes close to reflecting that view: the criteria for confinement are so vague that courts sit—when they sit at all—merely to review decisions made by psychiatrists. Indeed, the typical criteria are so meaningless as even to preclude effective review. In Connecticut, for example, the court is supposed to commit any person whom a doctor reasonably finds is "mentally ill and a fit subject for treatment in a hospital for mental illness, or that he ought to be confined." This circularity is typical of the criteria—or lack thereof—in about half of our states. Even in those jurisdictions with legal sounding criteria—such as the District of Columbia where the committed person must be mentally ill and likely to injure himself or others—the operative phrases are so vague that courts rarely upset psychiatric determinations.

The distorting effect of this medical model of confinement may be illustrated by comparing two recent cases from the District of Columbia. One involved Bong Yol Yang, an American of Korean origin who appeared at the White House gate asking to see the President about people who were following him and "revealing his subconscious thoughts." He also wondered whether his talents as an artist could be put to some use by the government. The gate officer had him committed to a mental hospital. Yang demanded a jury trial, at which a psychiatrist testified that he was men-

tally ill—a paranoid schizophrenic—and that although there was no "evidence of his ever attacking anyone so far," there is always a possibility that "if his frustrations . . . became great enough, he may potentially attack someone. . . ." On the basis of this diagnosis and prediction, the judge permitted a jury to commit Yang to a mental hospital, until he is no longer mentally ill and likely to cause injury.

The other case involved a man named Dallas Williams, who at age 39 had spent half his life in jail for seven convictions of assault with a deadly weapon and one conviction of manslaughter. Just before his scheduled release from jail, the government petitioned for his civil commitment. Two psychiatrists testified that although "at the present time [he] shows no evidence of active mental illness . . . he is potentially dangerous to others and if released is likely to repeat his patterns of criminal behavior, and might commit homicide." The judge, in denying the government's petition and ordering Williams' release, observed that: "the courts have no legal basis for ordering confinement on mere apprehension of future unlawful acts. They must wait until another crime is committed or the person is found insane." Within months of his release, Williams lived up to the prediction of the psychiatrists and shot two men to death in an unprovoked attack.

Are there any distinctions between the Williams and Yang cases which justify the release of the former and the incarceration of the latter? There was no evidence that Yang was more dangerous, more amenable to treatment, or less competent than Williams. But Yang was diagnosed mentally ill and thus within the medical model; whereas Williams was not so diagnosed. Although there was nothing about Yang's mental illness which made him a more appropriate subject for involuntary confinement than Williams, the law attributed con-

clusive significance to its existence *vel non*. The outcomes in these cases—which make little sense when evaluated against any rational criteria for confinement—are typical under the present civil commitment process. And this will continue, so long as the law continues to ask the dispositive questions in medical rather than legally functional terms, because the medical model does not ask the proper questions, or asks them in meaningless vague terms: Is the person mentally ill? Is he dangerous to himself or others? Is he in need of care or treatment?

Nor is this the only way to ask questions to which the civil commitment process is responsive. It will be instructive to restate the problem of civil commitment without employing medical terms and to see whether the answers suggested differ from those now given.

There are, in every society, people who may cause trouble if not confined. The trouble may be serious (such as homicide); trivial (making offensive remarks); or somewhere in between (forging checks). The trouble may be directed at others, at the person himself, or at both. It may be very likely that he will cause trouble, or fairly likely, or fairly unlikely. In some instances this likelihood may be considerably reduced by a relatively short period of involuntary confinement; in others, a longer period may be required with no assurances of reduced risk; while in still others, the likelihood can never be significantly reduced. Some people will have fairly good insight into the risks they pose and the costs entailed by an effort to reduce those risks; others will have poor insight into these factors.

When the issues are put this way, there begins to emerge a series of meaningful questions capable of traditional legal analyses:

What sorts of anticipated harm warrant involuntary confinement?

How likely must it be that the harm will

occur? Must there be a significant component of harm to others, or may it be to self alone?

If harm to self is sufficient, must the person also be incapable, because he lacks insight, of weighing the risks to himself against the costs of confinement?

How long a period of involuntary confinement is justified to prevent which sorts of harms? Must the likelihood of the harm increase as its severity decreases? Or as the component of harm to others decreases?

These questions are complex, but this is as it should be, for the business of balancing the liberty of the individual against the risks a free society must tolerate is very complex. That is the business of the law, and these are the questions which need asking and answering before liberty is denied, but they are obscured when the issue is phrased in medical terms which frighten—or bore—lawyers away. Nor have I simply manufactured these questions. They are the very questions which are being implicitly answered every day by psychiatrists, but they are not being openly asked, and many psychiatrists do not realize that they are, in fact, answering them.

Let us consider two of these questions and compare how they are being dealt with—or not dealt with—under the present system, with how they might be handled under functional, non-medical criteria.

The initial and fundamental question which must be asked by any system authorizing incarceration is: which harms are sufficiently serious to justify resort to this rather severe sanction? This question is asked and answered in the criminal law by the substantive definitions of crime. Thus, homicide is a harm which justifies the sanction of imprisonment; miscegenation does not; and adultery is a close case about which reasonable people may, and do, disagree. It is difficult to conceive of a criminal process which did not make some effort at

articulating these distinctions. Imagine, for example, a penal code which simply made it an imprisonable crime to cause injury to self or others, without defining injury. It is also difficult to conceive of a criminal process—at least in jurisdictions with an Anglo-American tradition—in which these distinctions were not drawn by the legislature or courts. It would seem beyond dispute that the question of which harms do, and which do not, justify incarceration is a legal—indeed a political—decision, to be made not by experts, but by the constitutionally authorized agents of the people. Again, try to imagine a penal code which authorized incarceration for anyone who performed an act regarded as injurious by a designated expert, say a psychiatrist or penologist.

To be sure there are differences between the criminal and the civil commitment processes: the criminal law is supposed to punish people for having committed harmful acts in the past; whereas, civil commitment is supposed to prevent people from committing harmful acts in the future. While this difference may have important implications in some contexts, it would seem entirely irrelevant in deciding which acts are sufficiently harmful to justify incarceration, either as an after-the-fact punitive sanction or as a before-the-fact preventive sanction. The considerations which require clear definition of such harms in the criminal process would seem to the psychiatrist's unarticulated judgments.

Yet the situation which I said would be hard to imagine in the criminal law is precisely the one which prevails with civil commitment. The statutes authorize preventive incarceration of mentally ill persons who are likely to injure themselves or others. Generally, "injure" is not further defined in the statutes or in the case law, and the critical decision—whether a predicted pattern of behavior is sufficiently injurious to warrant incarceration—is relegated to the psychiatrist's unarticulated judgments.

Some psychiatrists are perfectly willing to provide their own personal opinions—often falsely disguised as expert opinions—about which harms are sufficiently serious. One psychiatrist recently told a meeting of the American Psychiatric Association that "you"—the psychiatrist—"have to define for yourself the word danger, and then having decided that in your mind, . . . look for it with every conceivable means. . . ."

My own conversations with psychiatrists reveal wide differences in opinion over what sorts of harms justify incarceration. As one would expect, some psychiatrists are political conservatives while others are liberals; some place a greater premium on safety, others on liberty. Their opinions about which harms do, and which do not, justify confinement probably cover the range of opinions one would expect to encounter in any educated segment of the public. But they are opinions about matters which each of us is as qualified to make as they are. Thus, this most fundamental decision—which harms justify confinement—is almost never made by the legislature or the courts; often it is never explicitly made by anybody; and when it is explicitly made, it is by an unelected and unappointed expert operating outside the area of his expertise.

Consider, for example, the age old philosophical dispute about the government's authority to incarcerate someone for his own good. The classic statement denying such authority was made by John Stewart Mill in *On Liberty*. He deemed it fundamental:

That the only purpose for which power can be rightfully exercised against any member of a civilized community, against his will, is to prevent harm to others. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because . . . to do so would be wise or even right. . . .

The most eloquent presentation of the other view was made by the poet John Donne in a famous stanza from his *Dévotions*:

No man is an island, entire of itself;  
Every man is a piece of the continent,  
A part of the main;  
If a clod be washed away from the sea,  
Europe is the less . . . ;  
Any man's death diminishes me, because I am involved in mankind;  
And therefore never send to know for whom the bell tolls;  
It tolls for thee.

These statements—eloquent as they are—are far too polarized for useful discourse. In our complex and interdependent society, there is hardly a harm to one man which does not have radiations beyond the island of his person. But this observation does not, in itself, destroy the thrust of Mill's argument. Society may still have less justification for incarcerating a person to prevent a harm to himself, which contains only a slight component of harm to others, than if it contained a large component of such harm.

Compare, for example, a recent case which arose under the civil commitment process with a similar fact situation which produced no case at all. Mrs. Lake, a 62-year-old woman, suffers from arteriosclerosis which causes periods of confusion interspersed with periods of relative rationality. One day she was found wandering around downtown Washington looking confused but bothering no one, whereupon she was committed to a mental hospital. She petitioned for release and at her trial testified, during a period of apparent rationality, that she was aware of her problem, that she knew that her periods of confusion endangered her health and even her life, but that she had experienced the mental hospital and preferred to assume the risk of living—and perhaps dying—outside its walls. Her petition was denied,

and despite continued litigation, she is still involuntarily confined in the closed ward of the mental hospital. Compare Mrs. Lake's decision to one made by Supreme Court Justice Jackson who, at the same age of 62, suffered a severe heart attack while serving on the Supreme Court. As Solicitor General Sobeloff recalled in his memorial tribute, Jackson's "doctors gave him the choice between years of comparative inactivity or a continuation of his normal activity at the risk of death at any time." Characteristically, he chose the second alternative, and suffered a fatal heart attack shortly thereafter. No court interfered with his risky decision. A similar decision, though in a lighter vein, is described in a limerick entitled "The Lament of a Coronary Patient":

My doctor has made a prognosis  
That intercourse fosters thrombosis  
But I'd rather expire  
Fulfilling desire  
Than abstain, and develop neurosis.

Few courts, I suspect, would interfere with that decision. Why then do courts respond so differently to what appear to be essentially similar decisions by Mrs. Lake, Justice Jackson and the coronary patient? Because these similarities are obscured by the medical model imposed upon Mrs. Lake's case, but not upon the other two. Most courts would distinguish the cases by simply saying that Mrs. Lake is mentally ill, while Jackson and the coronary patient are not, without pausing to ask whether there is anything about her "mental illness" which makes her case functionally different from the others. To be sure, there are some mentally ill people whose decisions are different from those made by Justice Jackson and the coronary patient. Some mentally ill people have little insight into their condition, the risks it poses, and the possibility of change. Their capacity for choosing between the risks of liberty and the security of incarceration may

be substantially impaired. And in some cases, perhaps the state ought to act in *parens patriæ* make the decision for them. But not all persons so diagnosed are incapable of weighing risks and making important decisions. This has been recognized by some of the very psychiatrists who advocate the medical model most forcefully. Dr. Jack Ewalt, chairman of the Department of Psychiatry at Harvard, recently offered the following observation to a Senate Subcommittee:

The mentally sick patient may be disoriented, but he is not a fool. He has read the newspapers about overcrowded and understaffed hospitals. He is alert to the tough time he will have getting a job when he gets out, if he gets out. He knows that there lurks in the minds of his former friends the suspicion that he is a dangerous fellow. He is sensitive that a mother may recoil in fright if he stops to give her child a pat on the head.

But Dr. Ewalt uses this observation, not as an argument in favor of self-determination by the mentally ill, but rather as showing the need for medical commitment without judicial interference.

The appropriateness and limitations of such benevolent compulsion, are in the forefront of our concerns in the criminal law. (Witness the wide attention received by the Hart-Devlin debate.) Although there is as much reason for concern about these issues in the civil commitment context, they are being ignored, because the law has inadvertantly relegated them to the unarticulated value judgments of the expert psychiatrist.

This is equally true of another important question which rarely gets asked in the civil commitment process: how likely should the predicted event have to be to justify preventive incarceration? Even if it is agreed, for example, that preventing a serious physical assault would justify incarceration, an important question still remains; how likely should it have

to be that the person will assault before incarceration is justified? If the likelihood is very high—say 90 per cent—then a strong argument can be made for some incarceration. If the likelihood is very small—say 5 per cent—then it would be hard to justify confinement. Here, unlike the process of defining harm, little guidance can be obtained from the criminal law, for there are only a few occasions where the criminal law is explicitly predictive, and no judicial or legislative guidelines have been developed for determining the degree of likelihood required.

But someone is deciding what degree of likelihood should be required in every case. Today the psychiatrist makes that important decision; he is asked whether a given harm is likely, and he generally answers yes or no. He may—in his own mind—be defining likely to mean anything from virtual certainty to slightly above chance. And his definition will not be a reflection of any expertise, but again of his own personal preference for safety or liberty.

Not only do psychiatrists determine the degree of likelihood which should be required for incarceration; they are also the ones who decide whether that degree of likelihood exists in any particular case.

Now this, you may be thinking, is surely an appropriate role for the expert psychiatrist. But just how expert are psychiatrists in making the sorts of predictions upon which incarceration is presently based? Considering the heavy—indeed exclusive—reliance the law places on psychiatric predictions, one would expect there to be numerous follow-up studies establishing their accuracy. Over this past year, with the help of two researchers, I conducted a thorough survey of all the published literature on the prediction of anti-social conduct. We read and summerized many hundreds of articles, monographs, and books. Surprisingly enough, we were able to discover fewer than



a dozen studies which followed up psychiatric predictions of anti-social conduct. And even more surprisingly, these few studies strongly suggest that psychiatrists are rather inaccurate predictors; inaccurate in an absolute sense, and even less accurate when compared with other professionals, such as psychologists, social workers and correctional officials; and when compared to actuarial devices, such as prediction or experience tables. Even more significant for legal purposes, it seems that psychiatrists are particularly prone to one type of error—overprediction. In other words, they tend to predict anti-social conduct in many instances where it would not, in fact, occur. Indeed, our research suggests that for every correct psychiatric prediction of violence, there are numerous erroneous predictions. That is, among every group of inmates presently confined on the basis of psychiatric predictions of violence, there are only a few who would, and many more who would not, actually engage in such conduct if released.

One reason for this overprediction is that a psychiatrist almost never learns about his erroneous predictions of violence—for predicted assailants are generally incarcerated and have little opportunity to prove or disprove the prediction; but he always learns about his erroneous predictions of non-violence—often from newspaper headlines announcing the crime. This higher visibility of erroneous predictions of non-violence inclines him, whether consciously or unconsciously, to overpredict rather than underpredict violent behavior.

What, then, have been the effects of virtually turning over to the psychiatrists the civil commitment process? We have accepted a legal policy—never approved by an authorized decisionmaker—which permits significant overprediction; in effect a rule that it is better to confine ten men who would not assault than to let free one man who would. We have defined

danger to include all sorts of minor social disruptions. We have equated harm to self with harm to others without recognizing the debatable nature of that question.

Now it may well be that if we substitute functional legal criteria for the medical model, we would still accept many of the answers we accept today. Perhaps our society is willing to tolerate significant overprediction. Perhaps we do want incarceration to prevent minor social harms. Perhaps we do want to protect people from themselves as much as from others. But we will never learn the answers to these questions unless they are exposed and openly debated. And such open debate is discouraged—indeed made impossible—when the questions are disguised in medical jargon against which the lawyer—and the citizen—feels helpless.

The lesson of this experience—and our similar if less costly one with the insanity defense—is that no legal rule should ever be phrased in medical terms; that no legal decision should ever be turned over to the psychiatrist; that there is no such thing as a legal problem which can not—and should not—be phrased in terms familiar to lawyers. And civil commitment of the mentally ill is a legal problem; whenever compulsion is used or freedom denied—whether by the state, the church, the union, the university, or the psychiatrist—the issue becomes a legal one; and lawyers must be quick to immerse themselves in it. The words of Brandeis ring as true today as they did in 1927, and are as applicable to the psychiatrist as to the wire-tapper:

... Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.



## The Ownership of Hospital Records and Roentgenograms

Larry Fleischer \*

### Ownership of Hospital Records

The hospital record is an aid, a tool to the physicians, the nurses and to other professional personnel. The record enables them to have a detailed and current record of the patient's condition or progress. During the course of treatment, there is no more important record than the hospital record, for it contains all pertinent information on the patient's past and present medical history, his condition and treatment, based on reports made by the various departments, such as the X-ray department, pathology, operating room, consultants, attending physician, house staff and nurses.

Other essential information in hospital records includes: (1) correct spelling of name of patient and attending physician; (2) method of arrival; (3) description of condition of patient on admission; (4) admission temperature, pulse and respiration; (5) medication, dosage and manner of administration; (6) objective signs and subjective symptoms; (7) changes in appearance and medical condition; and (8) complaints.<sup>1</sup>

Hospital patient records fall into two groups: (1) ward patient, and (2) private and semiprivate patients. In the case of private and semiprivate cases, it is customary, at least in some hospitals, to obtain the attending physician's consent for release of information or for an examination of the record.

The attending physician has no right to determine who shall have access to the record after the chart is filed. However, his permission should be sought as a matter of courtesy. The attending physician of a semiprivate or private patient should know of requests to view the chart. If the attending physician

\* LL.B.; Member, Illinois Bar.

<sup>1</sup> Hayt, Groeschel and McMullan, *Law of Hospital and Nurse*, 317, 318 (1st 1958).

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declines to be concerned, the hospital should release the abstract to persons authorized by the patient.

The record librarian should let the final decision rest with the administrator as to whether the records should be released. Ordinarily, the administrator or custodian may be served with a subpoena duces tecum or an order from the court.<sup>2</sup>

The medical record in the hospital, by its very nature, may not only concern the patient, but other persons who may have an interest in the record in one way or another. Since many people are involved, one of the main questions of this article arises: Who owns hospital records?

The cases are few on which this question of ownership has been discussed. A case directly in point was *Wallace v. University Hospitals of Cleveland*.<sup>3</sup> In this case, plaintiff spent two months as a patient in the defendant university hospital. Desirous of obtaining detailed information concerning her injuries and treatment pursuant to a determination of damages in a lawsuit filed against another person, she authorized her attorney to obtain a copy of her hospital records at her expense. The defendant refused to deliver a copy of the record to the plaintiff.

Plaintiff in this action sought a mandatory injunction on the ground that she had a property right in the records. The hospital defenses were "that the records are the sole property of the hospital and that the plaintiff has no legal right to obtain them."<sup>4</sup>

The court concluded that the original hospital records were the property of the hospital. "Since they include the records of all births, deaths, nature and length of treatment and other information, their maintenance and custody is essential to the proper administration of the hospital. However, it is also true that a patient has a property right in the information contained in the record and as such is entitled to a copy of it."<sup>5</sup> The court's reasoning was that the patient or her physician's access to the records might in the future be a decisive factor in her

<sup>2</sup> Hayt, Hayt, and Groeschel, *Law of Hospital, Physician and Patient*, 655 (2nd Ed 1952).

<sup>3</sup> *Wallace v. University Hospitals of Cleveland*, 82 Ohio Law Abstract 224, 164 NE2d 917, 918 (1959).

<sup>4</sup> *Ibid.*

<sup>5</sup> *Ibid.*

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medical treatment. Also, the patient's attorney can use the hospital records to prove any question which may pertain to damages.

In this suit, the court granted the plaintiff a mandatory injunction compelling the hospital to provide the plaintiff with a copy of the record at the plaintiff's expense. Subsequently, the decree was modified so that the defendant was ordered to permit the plaintiff, or her attorney by her written permission, to inspect the hospital records under the hospital's supervision and to have copies made as in the discretion of the hospital was proper under the circumstances of the case. The hospital was instructed to bear in mind the interest of the plaintiff and the general purpose of the records.<sup>6</sup>

Thus, we can conclude from the Wallace case that the hospital owns the original records, subject to a property right of the patient in the information and a right to have access to the records.

The ownership of hospital records was also discussed in *Pyramid Life Ins. Co. v. Masonic Hospital Ass'n.*<sup>7</sup> The plaintiff issued policies of insurance, covering hospital, doctors, and medical bills. The plaintiff in its complaint asked for a mandatory injunction enjoining and restraining the defendants (the hospital and the administrator of the hospital) from preventing inspection and copying of hospital and medical records of patient policyholders of the plaintiff who had been confined in the defendant hospital, by representatives of the plaintiff, armed with authorizations signed by the patients or their representatives. Plaintiff's reason for this complaint was for a discovery and accounting of any monies found due and owing by the defendant hospital association to the plaintiff because of claims paid by the plaintiff to the hospital through fraud of the defendant or mistake of fact by the plaintiff.

The issues in this case were similar to the Wallace case, but here we have an insurance company with a patient's authorization to inspect and have a copy of the record. The court in this case based its decision on two grounds. The first ground

<sup>6</sup> *Wallace v. University Hospitals of Cleveland*, 84 Ohio Law Abstract, 170 NE2d 261, 262 (1960).

<sup>7</sup> *Pyramid Life Ins. Co. v. Masonic Hospital Ass'n*, 191 F Supp 51 (WD Okla 1961).

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was that the statute of Oklahoma required hospitals as the defendant "to keep and retain accurate and complete medical records of its patients." These records were considered quasi-public, since the records were required to be kept by the force of a statute.<sup>8</sup> "Inspection can be made by any person who has an interest such as would enable him to defend an action for which the document or record sought can furnish information."<sup>9</sup>

The court then proceeded to rule in accordance with the Wallace case and found that the original hospital records were the property of the hospital. However, "the keeper of the records does not have the right to possess and use the information constituting the records to the exclusion of the patient, his representatives or those standing in his shoes."<sup>10</sup> The paper and material maintained by the hospital is the property of the hospital. "Accordingly, the keeper of the records is only the custodian and not the owner of that information constituting the medical records of the patient."<sup>11</sup>

In another case involving the Pyramid Life Ins. Co.,<sup>12</sup> under an identical set of facts, the rights of an insurance company were again discussed in relation to the patient's right of ownership in the information. The court stated: "Hospital records are kept for the benefit of the patient, the hospital and the physician, and are an essential part of the contractual relationship between the hospital and the patient; the patient's interest and right in his hospital records is said to be superior to that of either the hospital or the physician. In both cases it is said the fiduciary relationship and the right of the patient to a full and frank disclosure of all the facts relating to his physical condition vests the patient with the exclusive control over the review of his medical records by third parties."<sup>13</sup> Thus, the second Pyramid case reiterates the conclusion in the first Pyramid case and states that the patient may even assign his rights to third parties, such as insurance companies.

<sup>8</sup> *Wilson v. United States* 221 US 361, 382 (1911).

<sup>9</sup> *Supra*, n 7 at pp 51 and 54.

<sup>10</sup> *Ibid.*

<sup>11</sup> *Ibid.*

<sup>12</sup> *Pyramid Life Ins. Co. v. Gleason*, 188 Kan 95, 360 P2d 858 (1961).

<sup>13</sup> *Ibid.*, p 861.



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In addition to the cases, the hospitals permit the lawyer access to these records. Dr. Nathan Flaxman, in an article, has stated: "It is customary among hospitals to permit the lawyer for the patient to view the hospital record upon the receipt of a written authorization from the patient."<sup>14</sup> Dr. Flaxman proceeds to conclude the ownership of the records as the cases have. Dr. Flaxman states: "The medical record is the property of the hospital, but such records are compiled and kept primarily for the benefit of the patient."<sup>15</sup>

In my opinion, I believe the question of ownership of hospital records can be summed up in three points: (1) The hospital is the owner of the original hospital records, (2) the hospital is only custodian of the information, and (3) the patient has a property right in the information which appears in the records. Thus, it is important to note that the hospital owns the original records, but the patient has a property right in the information.

### Ownership of Roentgenograms

The next topic under discussion also pertains to a medical record, but to a specific, rather than a general, record. The query is: Who owns X rays, or, to put it in the more technical name for X rays, who owns roentgenograms?

A distinction must be made between a photographic negative and a roentgenogram. Most of the authorities have agreed that a photographer who is employed to make a negative and photograph in his usual course of business has no right to use the negatives for his own purposes. The theory is that there is an implied contract that the photographer shall not use the plates.<sup>16</sup> However, the situation is different with respect to X rays.

X-ray pictures are not pictures as the word is used in its ordinary and expected meaning, but the result of the highly technical and professional procedure of registering on highly sensitized and perishable material reflexes of bone structure, organs and foreign bodies lodged within animal bodies and invisible to the eye. The roentgenogram is produced through

<sup>14</sup> Flaxman, Clues in Medical Record, 1957 Medical Trial Technique Quarterly 45.

<sup>15</sup> Ibid.

<sup>16</sup> Annot 24 ALR 1320.

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the use of machines or apparatus of scientific manufacture and operable only by roentgenologists or persons schooled and expert in the manipulation of such machines. These machines when operated give off a form of radiant energy emanating from the surface of an electrically excited vacuum tube opposite the cathode electrode having the power of penetrating objects impervious to light or heat rays, affecting sensitive photographic films, and exciting florescence in certain solutions. When a member of the body is exposed to these roentgen rays over the sensitized plates, the recordings are manifest on the plate through outlines and shadows.<sup>17</sup>

The roentgenogram, thus, is the foundation of the roentgenologist's diagnosis. Through these outlines and shadows, the roentgenologist can make readings as to whether there is a fracture, dislocation, or any other malfunction of the body structure.

The main difference between a photograph negative and a roentgenogram is that the purpose for each is vastly different. A person who presents himself to a photographer to be photographed expects to receive a photograph, whereas a person who presents himself to a roentgenologist expects to receive an opinion or advice as to the roentgenogram. Seldom does the person expect to receive the roentgenogram. Ordinarily, persons who present themselves to roentgenologists await the report from their physicians. They do not stop, before being roentgenographed, to ask whether or not they are going to receive a roentgenogram of themselves.

Among roentgenologists and physicians generally, there is a common understanding as to the ownership of a roentgenogram. A formal statement of the understanding by a representative professional group is to be found in resolutions adopted in 1920 by the Radiological Society of North America. There it is expressed that all roentgenograms, plates, films, negatives, photographs, tracings or other records of examination are the exclusive property of the roentgenologist who made them or the laboratory where they were made. It is declared that the roentgenologist is a professional man whose opinion and advice are sought; he is not a mere technician

<sup>17</sup> Martin, Ownership of X-Ray Plates, 46 NYSJM 654 (1946).



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as a photographer, paid to make a certain kind of photograph called a roentgenogram.

The resolutions also state that the fact that a roentgenogram was made by a hospital, through its roentgenologist, does not alter the situation except that it makes a stronger case for the retention of the roentgenogram by the hospital. The theory behind this is that a hospital may make such reasonable regulations as are necessary for its efficient management. Thus, if any such regulation is, in fact, brought to the attention of a patient or a physician using the hospital, or if he has actual knowledge of that regulation before he enters, he is bound by it. In addition, the fact that the regulation is posted in and about the hospital, or even the fact that it has been customarily followed for a long time would tend to prove such knowledge on the part of a patient or physician and to bind him accordingly.<sup>18</sup>

In addition to the Radiological Society, the American College of Radiology has adopted certain policies regarding ownership of roentgenograms, for the guidance of hospitals and physicians.<sup>19</sup> They are as follows:

1. Roentgenograms should be used for the best interests of the patient.
2. The roentgenograms are the legal property of the radiologist or of the hospital in which they are made. It is advisable, but not necessary, to mark on each film the statement "Property of Dr. John Doe." Such a mark is particularly desirable if the radiologist delivers the films to the referring physician instead of filing them in his office or hospital department.
3. It should be the policy of the radiologist to make the films available for inspection by the physician who referred the patient for X-ray examination, along with a copy of the report of the radiologist. The best results are undoubtedly obtained when it is possible for the radiologist and the referring physician to confer personally when the latter views the films.

<sup>18</sup> Trostler, Ownership of Roentgenograms and Hospital Records, 88 American Medical Society 1985 (1927).

<sup>19</sup> Who Owns the Films—American College of Radiology Supplies the Answer, 67 Mod Hosp 61 (1946).

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4. If the referring physician, or if the patient in behalf of the referring physician, wishes to take the films away from the office or the hospital, it should be clearly understood that the films are "on loan" and should be returned after the loan has served its purpose.
5. If the patient dismisses the referring physician and goes to another physician, the films and the report should be made as freely available to the second as they are to the first physician who originally referred the patient. It is desirable that the patient notify the first physician of the change and it may be assumed that he has done so, but even if this notification has not been made, the obligation of the radiologist is unchanged. When the second physician wishes to examine the films, it is assumed that he is doing so at the request of the patient.
6. If the referring physician objects to the submission of the films to the second physician or to giving to the latter a copy of the radiologist's report, the radiologist is obligated to do so in spite of this objection. If the referring physician has possession of the films and refuses to release them, the radiologist, whose legal property they are, has the right to take whatever action is necessary to get the films for the further benefit of the patient.
7. All films should be legibly and permanently marked so that the patient can be identified and the date on which they were taken can be determined. This is important because, under some conditions, a comparison of films just made with others made previously may be the crucial factor necessary to establish a diagnosis or to estimate the progress or regression of a disease.
8. When a medicolegal situation exists, the radiologist has a right to refuse to release the involved films if necessary for his own protection, except on a court order.
9. A liberal attitude regarding the release of films is more desirable than strict insistence on one's legal rights. It is better to run the occasional risk of losing films than to engender the enmity of a patient or of a physician by strict adherence to the rule which, in the past, has led to attempts to make laws making the films the legal property of the patient.

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From the foregoing promulgations by the medical profession, the roentgenologist or his principal is the owner rather than the patient. Thus, the roentgenologist has greater rights in a roentgenogram than a photographer has in a photograph or negative, according to the stated promulgations of the medical profession.

The cases regarding ownership of roentgenograms, like the cases regarding ownership of hospital records, have been few. Nevertheless, there is law in point on this subject.

In *Hurley v. Gage*, Genesee County, Michigan circuit court (1932), the court ruled in favor of a hospital as to the ownership of a roentgenogram. The court pointed out that the hospital sold and patients paid for, not the material that went into roentgenograms, but knowledge and experience.<sup>20</sup>

In a later case, cited in an article by William F. Martin, counsel to the Medical Society of the State of New York, the subject of the ownership of roentgenograms was discussed. The case came from the Small Claims Court of the Municipal Court of the City of New York. In this case, the plaintiff was injured by a taxicab. His attorney recommended that he call upon defendant B, a duly licensed practicing physician of the State of New York. Defendant B requested the plaintiff to call upon defendant S, another licensed and practicing physician of New York, and one specializing in roentgenograms. The plaintiff proceeded to submit to roentgenograms taken of his foot and lower limb. After taking such pictures, the defendant S was paid for his services and thereafter forwarded the roentgenograms, together with his written report of his findings, interpretations, opinions, and diagnosis, to the defendant B. A report was then sent to the attorney who had recommended B. Defendant B was paid, and the roentgenogram plates were still retained by defendant B. Subsequently, Mr. C, attorney for the plaintiff in this case, requested defendant B to turn the roentgenograms in question over to him as the substituting attorney for the plaintiff. The plaintiff also made a formal written request to the defendants to turn the roentgenograms over to Mr. C; neither of the said demands were complied with.

<sup>20</sup> Donaldson, *Medicolegal Considerations of X rays*, 19 *Radiology* 388, 391 (1932).

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The court ruled that the roentgenograms were not the property of the plaintiff patient; that the roentgenologist was the owner of the plates. Honorable O. Grant Esterbrook stated: "It is essential that he (roentgenologist) retain it as a permanent record in support of his diagnosis for should it be destroyed by unskillful handling or loss, the roentgenologist would have no means to justify the correctness of his diagnosis or findings in the event of challenge to his professional opinion. What the plaintiff sought was a diagnosis of his ailments and professional advice as to how to treat them to effect a cure, and even though the X-ray plates were taken of the plaintiff's foot and lower limb, they were so taken with his knowledge and consent that they were to be delivered to his physician for his professional aid and use and not as a work of art . . . The X-rays are the property of the defendants in the absence of an implied agreement."<sup>21</sup>

It is quite evident from this lower court case and from the medical profession's promulgations that the retention of possession and ownership of all of the X-ray films made in connection with professional care rendered to a patient is a matter of extreme importance to the attending physician. It is, of course, always desirable to have the films available to meet any future needs of the patient, whether professional service is rendered by the same or another physician. In the event that another physician is substituted on the case, copies of the X-ray reports and/or an opportunity to study the films taken should routinely be given or allowed.<sup>22</sup>

Certain inferior courts, small claims and justice courts, have placed ownership of X rays in the hands of the patient, taking the films from the possession of the physician. These holdings apparently are not in agreement with the reasoning that when a patient submits himself for a roentgenogram, he is merely contracting for advice and an opinion, and not for the ownership of the negative. Whenever and wherever decision or statute makes it advisable and necessary for the physician to protect his right to possession of X-ray films, it is recommended that the patient's agreement to that end be required. The following form might be useful.

<sup>21</sup> *Infra*, n 22.

<sup>22</sup> Regan, *Doctor and Patient and the Law*, p 33 (2nd Ed 1949).

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ORDER FOR TAKING OF X-RAY FILMS <sup>23</sup>

Date \_\_\_\_\_

Place \_\_\_\_\_

1. I hereby order the taking of X-ray exposures and films of parts of the person of \_\_\_\_\_ as follows: \_\_\_\_\_.

2. I agree, in part consideration of Dr. \_\_\_\_\_'s undertaking to render professional service to the person named above, that all such X-ray exposures taken and films made by Dr. \_\_\_\_\_, or by any other person at his request, whether or not paid for by the undersigned, shall become a part of Dr. \_\_\_\_\_'s professional records and shall be subject solely to his control and disposition.

3. In addition to the foregoing, I agree to pay charges in the amount of \$\_\_\_\_\_ for services rendered pursuant to this order.

Signed \_\_\_\_\_

Witness \_\_\_\_\_

The next case to be discussed is evidently the only one in which the question of ownership of X-ray films has been directly decided by a court of appellate jurisdiction. The case is McGarry v. J. A. Mercier Co.,<sup>24</sup> which involves a suit by a physician for services rendered. One of the defendant's employees, Miller, was injured in the course of his employment. Plaintiff was engaged by the defendant to give the injured employee professional care. Defendant declined to pay the bill when presented. Defendant in the suit seeks to avoid payment because the plaintiff refused to deliver to defendant for use by other physicians X-ray negatives which plaintiff had taken incident to treating Miller, although plaintiff was willing that the negatives could be inspected by other physicians if not removed from the plaintiff's clinic.

The court held that the plaintiff was fully justified in refusing to surrender possession of the X-ray negatives. Justice North stated: "In the absence of agreement to the contrary, such

<sup>23</sup> Medicolegal Forms with Legal Analysis, p 9, Law Department, American Medical Association (1961).

<sup>24</sup> McGarry v. J. A. Mercier, 272 Mich 501, 262 NW 296 (1935).



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negatives are the property of the physician or surgeon who has made them incident to treating a patient. It is a matter of common knowledge that X-ray negatives are practically meaningless to the ordinary layman. But their retention by the physician or surgeon constitutes an important part of his clinical record in the particular case, and in the aggregate these negatives may embody and preserve much of value incident to a physician's or surgeon's experience. They are as much a part of the history of the case as any other case record made by a physician or surgeon. In a sense they differ little if at all from microscopic slides of tissue made in the course of diagnosis or treating a patient, but it would hardly be claimed that such slides were the property of the patient. Also in the event of a malpractice suit against a physician or surgeon, the X-ray negatives which he has caused to be taken and preserved incident to treating the patient might often constitute the unimpeachable evidence which would fully justify the treatment of which the patient was complaining. In the absence of an agreement to the contrary, there is every good reason for holding that X rays are the property of the physician or surgeon rather than of the patient or party who employed such physician or surgeon, notwithstanding the cost of taking the X rays was charged to the patient or to the one who engaged the physician or surgeon as a part of the professional services rendered."<sup>25</sup>

To sum up the question of ownership of roentgenograms, the patient is not entitled to a roentgenogram in the absence of an agreement. The patient, who usually lacks the skill and knowledge to appreciate the significance of the roentgenogram, contracts for advice or an opinion concerning the roentgenogram, not for its ownership or possession.

<sup>25</sup> Ibid., p 297.



# MORALS AND MEDICINE

THE MORAL PROBLEMS OF:

*The Patient's Right to Know the Truth*

*Contraception*

*Artificial Insemination*

*Sterilization*

*Euthanasia*

BY JOSEPH FLETCHER

WITH A FOREWORD BY KARL MENNINGER, M.D.

BEACON PRESS BEACON HILL BOSTON

## CHAPTER TWO

### MEDICAL DIAGNOSIS: OUR RIGHT TO KNOW THE TRUTH

#### *The Truth Can Hurt*

A GENTLEMAN," said Dr. John M. Birnie in the *New England Journal of Medicine*, "is one who has more regard for the rights of others than for his own feelings, and for the feelings of others than for his own rights." Disraeli, bemused by the troublesome problem of truth-telling, put it this way: "A gentleman is one who knows when to tell the truth, and when not to." His diplomatic impulses served him better than the cynic's who observed that "a gentleman is one who never unintentionally hurts the feelings of others." But Dr. Birnie meant, presumably, that the gentle person is one who avoids saying anything that *needlessly* hurts a person's feelings.

The issue over truth-telling in medical diagnosis and advice raises the question, therefore, whether doctors can be "gentlemen" and at the same time meet their obligations to the patients under their care. What, to be quite to the point about it, is the duty of the physician in sharing his diagnosis and prognosis? Is he under any obligation morally to reveal his findings to his patient, even if it hurts to know them? Has the patient, in his turn, a right to expect the truth? Or are we to accept the bold claim by Dumas' heroine in *Camille* who declared, "When God said that lying was a sin, he made an exception for doctors, and he gave them permission to lie as many times a day as they saw patients"? It is an old and perennial problem, giving cause in every age to complaints against doctors as masters of equivocation, complaints sometimes made with great hilarity by a Gregory Glyster.<sup>2</sup> This

<sup>1</sup> 205.1126, "Ethics for the Doctor."

<sup>2</sup> *A Dose for the Doctor; or, the Aesculapian Labyrinth Explored in a Series*

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is the kind of question in people's minds which popular interpreters never undertake to clarify.

We have already set forward the premise that moral status (our ethical integrity) depends upon two things at least: first, freedom of choice, and, second, knowledge of the facts and of the courses between which we may choose. In the absence of either or both of these things we are, in the forum of conscience, more like puppets than persons. Lacking freedom<sup>3</sup> and knowledge, we are not responsible; we are not moral agents or personal beings. We have pointed out, furthermore, that mankind is constantly growing and gaining ground both in knowledge of life and health and in human control over them. This is, indeed, the same as saying that the *means* to heightened moral stature are available. The appeal of moral idealism is that we take advantage of every opportunity to grow in wisdom and stature, that we *assume* our responsibility; in short, that we act like human beings. As far as medical care is concerned we can only repeat what we said above: "Without their freedom to choose and their right to know the truth, patients are only puppets. And there is no moral quality in a Punch and Judy show; at least, there is none in Punch or Judy!"

Dr. Birnie's dilemma was a real one. Sometimes the doctor's discoveries are appalling. To whom, then, shall he give his findings? As a gentleman he hates to hurt his patients' feelings, to depress them, or possibly to drive them to despair. When the truth about our health is a bitter pill to swallow, known as yet only to the physician and perhaps not even suspected by those who put themselves in his hands, he will of course have compassionate regard for their

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*of Instructions to Young Physicians, Surgeons, Accoucheurs, Apothecaries, Druggists and Chymists, Interspersed with a variety of Ridiculous Anecdotes Affecting the Faculty. Inscribed to the College of Wigs, by Gregory Glyster, an old practitioner. London, 1789. In the Warren Collection, Harvard Medical School Library.*

<sup>3</sup> By freedom we mean *physical* freedom, what we *can* do; not moral freedom, referring to what we *may* do.

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feelings. For this reason—a perfectly understandable one—Dr. Birnie concluded that “in hopeless cases, it is cruel and harmful to tell the patient the truth,” and even if the doctor tells some member of the family it will be necessary for both “to lie like gentlemen.”<sup>4</sup> It is a hoary old problem of conscience in medical care. For our purposes we may attempt to explore it by posing two questions between which to shuttle back and forth. They are really obverse sides of the same coin, but they represent two distinguishable issues involved. First, has the patient a *right* to know the truth about himself? Next, has the doctor an *obligation* to tell it? Most of us upon occasion are patients, but only a few are physicians. The discussion, therefore, will naturally and properly tend to emphasize the first viewpoint and its question, namely, the *patient's right*.

If the doctor is thus obliged to tell the truth, what difference would it make if the patient is not sure he wants to know it, or if he actually does not want to know it? This question raises a matter of almost crucial importance for psychotherapy, and even for the less pathological areas of clinical counselling. And (most difficult of all) what if the doctor cannot know whether the patient wants to know? Is there a valid principle of therapeutic reservation when it comes to truth-telling in medical diagnosis? Very good reason would have to be found—better, at least than has ever been brought forward—to justify us in avoiding the answer that follows from the premise that our moral stature is proportionate to our responsibility and that we cannot act responsibly without the fullest possible knowledge. The patient *has* a right to know the truth. We are morally obligated to pay others the rights due them. Therefore a doctor is obligated to tell the truth to his patient. He *owes* the patient the truth as fully and as honestly as he owes him his skill and care and technical powers.

<sup>4</sup> Birnie, *op.cit.*, same place.



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We have already expressed the view that "a person-centered approach to illness is superior to the problem-centered approach." To support it we quoted Dr. Francis Peabody's thesis that "one of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is caring *for* the patient."<sup>5</sup> What does it mean to care *for* somebody? The mere business of taking care *of* a person may be entirely a matter of efficiency, and quite impersonal, as many of us have discovered by watching the ministrations of a very young or very bored nurse (or waiter, clerk in a store, barber, or dentist). Caring *for* a person, on the other hand, is a decidedly moral relationship. The phrase "care for" has even come in popular speech to mean love or highly affectionate regard. It means, of course, that we have a care, a sense of concern. A man is said to care for his wife, and that means vastly more than providing for her physical needs; it means a lot more than offering fuel, shelter, food, and clothing. It means, indeed, that he has an attitude of respect and solicitude towards her in all things. So should the doctor's attitude be toward his patient. The sufferer is not just a case of pneumonia or pyloric stenosis or peptic ulcer; the patient is a person, with feelings of hope or despair, of purpose or defeat, of loneliness or fraternity. The patient is not a problem; he is a person with a problem.

From the point of view of morality, we might look at this question as it would be seen by Martin Buber, philosopher at the University of Jerusalem.<sup>6</sup> There is, as Buber points out, a radical difference in a man's attitude to other men and his attitude to things. In the one case we are related to other persons, like ourselves, to another subject, a *thou*. In the other case we are related to objects, to things, to *its*. These are the two attitudes with which we relate ourselves to what

<sup>5</sup> See ch. 1, n. 13.

<sup>6</sup> *I and Thou*, trans. by R. G. Smith, Edinburgh, 1937. Cf. also by the same author, *Between Man and Man*, New York, 1948, pp. 1-80, 118-205.

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is other than ourselves. A doctor's patient is a person, a *thou*, someone with an integrity and a moral quality of his own. Relationship to persons is a moral experience because persons are responsible (they can *respond*). Unlike things, they can say "yes" or "no." They have rights, especially the right to say "yes" or "no" in response (in being responsible), the right to self-determination, the right to be themselves, to choose; in short, to be a *thou* and not an *it*, a subject and not an object.<sup>7</sup>

The ethical importance of this distinction is plain enough. We have reasoned thus far that the moral stature of men and women is directly proportionate to the freedom they enjoy, that their freedom to choose is, in its turn, proportionate to the control they have gained over their alternatives of action and to *the knowledge they possess of the alternatives open to them*. If a patient is simply an object of medical treatment, who submits without any knowledge of his condition and its prognosis, that patient has ceased to be a *thou*, has become an *it*. He is being manipulated as a thing, not met and accredited as a person. He has lost his place in the forum of conscience; he is deprived of responsibility and therefore of moral status. This is the ethical implication of the belief that physicians ought to serve according to the demands of a person-centered rather than of a problem-centered approach to the patient's suffering.<sup>8</sup> Something of this philosophy of practice is surely working like a leaven in the medical schools and in the profession itself. It was a common feature of the work of the old country doctor, even though his role has been somewhat romantically colored from time to time. When medical technology and urbanism had not yet outmoded the practice of medicine out of a little

<sup>7</sup> This dialogical thesis in one of its dimensions is a refreshing reformulation of Kant's old axiom: so act as to use humanity, both in your own person and in others, always as an end and never as a means.

<sup>8</sup> The doctor must do both things, however, for all the sympathy in the world will not compensate for a wrong diagnosis.



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black bag, it was psychologically easier to maintain a strong personal factor in the physician-patient relationship. The dangers of specialism, in this regard, have stimulated efforts to recover the human values of general practice, as we may see in the experiments of the Peter Bent Brigham Hospital and the Harvard Medical School in teaching "integrated medicine." As Dr. Henry M. Fox, director of the unit, says: "The pendulum which has swung so far from the personal interest of the country doctor to the more detached attitude of the specialist is now swinging back to a halfway mark maintaining the good features of each."<sup>9</sup> In public reports of this study it is significant that one of its features receiving special attention is an effort to discover whether the patient "needs more information to relieve his worries or his wonderment about what is going on."<sup>10</sup>

### *"What Is Truth?"*

To say, however, that the doctor owes the truth to his patient does not altogether cover the ground of conscience involved. First of all, we ought to recognize that this right to know the truth does not apply to all truths. There are secrets of others, for example, to which few if any of us have any right at all. Furthermore, the classic question put by Pilate to Jesus, "What is truth?" can be applied to the problem of medical diagnosis and truth-telling.<sup>11</sup> As Pilate's question seems to have been intended to suggest, none of us has perfect knowledge; also, the human intelligence with which we try to make sense of what knowledge we have is not infallible. Given a doctor's willingness and desire to respect the patient's right to know the truth, how shall he convey it? How can he be *sure*? In the tradition of ethics and moral theology in Western Christendom it has generally been said that truth is of two kinds, logical truth and moral

<sup>9</sup> *Boston Sunday Herald*, July 15, 1951.

<sup>10</sup> *Ibid.*

<sup>11</sup> John 18:38.

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truth. This distinction appears to have considerable bearing upon the problem of truth-telling as between physician and patient. Logical truth (or accuracy) is the correspondence of outward or verbal expressions to or with the matter which is the subject of the expression. Moral truth (or veracity) is the correspondence of the outward expression given to our thought, with the thought itself. Accuracy, in other words, is telling the truth as it actually is, at least as far as our knowledge of it goes; veracity is telling the truth honestly and not withholding or changing or obscuring a part of what we believe to be true.

When it comes to telling the truth, we can never be sure that we know it, nor can we always be sure that we convey it as we *do* know it or believe it to be. Our modern sociology of knowledge, and psychology with its new understanding of the subtleties of communication and the role of the unconscious, have humbled us a great deal about our capacity either to grasp or to convey the truth. But these considerations are only cautionary; they have to do only with the negative defects of truth, due to human limitations, not with positive injuries to the truth, due to willful distortion and suppression. Problems of morality or of conscience in connection with truth-telling arise only in the case of moral truth (veracity), not with logical truth (accuracy).

It is presumed that inaccuracy or error, in the case of medical advice or in any other area, is unintentional and therefore by definition entirely outside the forum of conscience. In short, as far as morality is concerned (although not so far as science is concerned) what is at stake in telling the truth is, precisely, honesty. Dr. John Homans once protested, "There can be no universal rule to tell the brutal truth. And the first and best reason for not telling the truth is the impossibility of being certain what the truth is."<sup>12</sup> But this admitted fact is too often a red herring, drawn across the

<sup>12</sup> *The Cure of the Patient from the Surgeon's Standpoint*, Boston, 1934.



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trail to confuse conscience, since it bears only upon the problem of accuracy, not upon the problem of honesty. Indeed, a part of the truth which the doctor owes the patient is just that: that the doctor cannot be absolutely correct. After all, doctors, like their patients, have to be prepared to meet frustration through knowledge. Their very science often gives them an insight into bitter realities which would leave the primitive medicine-man, who could not know, reasonably hopeful. To take refuge in finitude to avoid reality is only a sophisticated form of escapism, when it is used as an excuse for departing from honesty. No: the question before us really is: *are we obliged to tell the truth as we see it according to our best knowledge?* For this very reason it is a matter of simple justice that the law does not require a physician to be responsible for errors in judgment, or to possess any unusual skill beyond the average. This is the principle of law under which every issue of professional responsibility is adjudicated. Indefectibility of the person—whether in knowledge, skill, or strength—is assumed to be out of the question. Therefore, to deny the obligation of truth-telling by pointing to human limitations is neither here nor there.

St. Augustine said a lie is always and necessarily sinful.<sup>13</sup> Thomas Aquinas in the Middle Ages said, "A lie has the character of sinfulness, not only from the damage done to a neighbor, but also from its own inordinateness. . . . And therefore [he concludes] it is not lawful to tell a lie to deliver another from any danger whatever."<sup>14</sup> It is true that St. Thomas went on to say, "It is lawful, however, to hide the truth prudently under some dissimulation, as Augustine says." But this reference to St. Augustine's opinion (in *De mendacio*, 2) that we are permitted to tell an obvious, joking fib, deliberately shown to be such by one's tone of voice and manner, does not alter the principle at all. For such lying

<sup>13</sup> *Enchiridion*, 18; *De mendacio*, 6.21.

<sup>14</sup> *Summa theologiae*, ii-ii.110.3ff.

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is legitimate since, after all, a lie which advertises itself as such is no longer really a lie. Or, again, a lie which is of the nature of evident fiction is not a real falsehood. Also, there are times when, as Jeremy Taylor put it in the seventeenth century, "we may lie to children and idiots." He tells of how one Hercules of Saxonia, a medical practitioner, saved the life of a madman who imagined himself to be Elijah and refused to take food, by sending him a "fellow dressed like an angel" with the command to rise and eat.<sup>15</sup> Here, in this patient, was a lack of moral capacity or responsibility. Such sufferers are, in this respect, like children who are irresponsible through inexperience, and like idiot who lack moral capacity through mental deficiency. They are not morally responsible agents. But adults, as Taylor himself insisted, *are* persons of responsibility. Yet he explains without protest that in his day "to lie like a physician" was a complimentary remark.<sup>16</sup> It is also interesting, in this connection, to see how the author of *Holy Living* and *Holy Dying* was entirely ready to permit a doctor to lie to his patient, even when dying, whereas he would have been morally outraged had a priest lied to the same patient! The sacrament of extreme unction and last Confessions are practices whereby ministers of religion demonstrate that *they* do not scruple to let the dying or the seriously ill know the real situation. Here again is that curious and persistent assumption (working like an ethical termite) that the doctor is dealing with a body, a physical *thing*, and that he therefore has no moral obligation to the patient's personality and spiritual integrity. It assumes, at least, that the doctor has none compared to the obligations of a priest or pastor on the spiritual level. But from any view except the crudest materialism, the physician is just as responsibly related to the patient as a moral subject

<sup>15</sup> *Ductor Dubitantium*, iii.2,5; i.5,8, par. 28.

<sup>16</sup> Cf. a parallel discussion in K. E. Kirk, *Conscience and Its Problems*, London, 1927, p. 123.



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as any priest could be, for the spirit and the body are one.

In our day doctors commonly act according to Taylor's latitude.<sup>17</sup> The indecision and evasion over the nature of a lie, which we all have felt and fought with, is seen in the public words of one practitioner, whom we shall leave unidentified even though his statement was part of a lecture to medical students: "Personally, I can, I think, truthfully say that in a practice of forty years I never, as far as I can remember, found it necessary to tell an outright lie to a patient about his condition. Tactful and skillful explanations with their if's and and's, side issues and suggestions of possibilities, always sufficiently befogged the issue, satisfied the patient, and left my conscience unscared. A sick man is not a well man and what would be injudicious to say to the one is often swallowed with almost a real relish by the other." Here, in these tortuous terms, are all the involutions of our problem!

From the earliest times it has been argued that a lie is not a lie if there is a just cause for it. Among such just causes men have included self-defense, military necessity, and even zeal for God's honor! The kindly old Jesuit of the *Provincial Letters* was no purely modern phenomenon. Pious frauds, miracle stories, false decretals, bogus relics, and the like are an early and common story. Cardinal Newman felt that the majority of church moralists had by their defense of falsehood *per causa justa* further impaired the Christian's sense of truth.<sup>18</sup> Theologians argued that since faith need not be kept with a tyrant or a robber, it is still less to be kept with a heretic who kills the soul. Gregory of

<sup>17</sup> A leading Catholic moralist says, "A deplorable pagan custom is in vogue among many doctors today—the custom of deceiving their patients about their condition so effectively that they slip out of life without realizing that they are dying." F. J. Connell, *Morals in Politics and Professions*, Westminster, Md., 1945, p. 122.

<sup>18</sup> *Apologia pro vita sua*, New York, 1865, 291ff., esp. p. 300; on the principle of *Corruptio optimi est pessima* he reproves the amphibologia of the casuists and their economy of truth.

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Nyssa, Origen, and most of the later Fathers even argued that God himself used deceit in dealing with his enemy the Devil. He did so, they said, by offering him Christ's soul in exchange for the souls of sinful men, knowing all the time that the Devil could not *keep* the ransom paid him, since the soul of Christ was sinless and would torture the Devil unbearably. Some Christians in the past have tried to defend the lies recorded in the Bible. Since the Bible gives a more or less outright condemnation of lying in certain passages, these attempts have usually been made to prove that the lies were not really lies at all, and thus that they are conformable to the theory that there is no internal contradiction in Holy Writ. They have written some marvellous commentaries on Rahab's lie, and that of the midwives in Egypt; on Jehu's sacrilegious Baal-worship in order to slaughter the Baal-worshippers; on David's trickeries; Jacob's deception of Isaac; Abraham's lie about Sarah and hers to the angel. The opinion condemning lying, quoted above from St. Augustine, was written as part of an answer to St. Jerome's attempt to explain away the statement in Galatians 2:11 that two saintly apostles disagreed and struggled against each other over the question of eating with Gentiles. Paul accuses Peter of being a sycophant and a weathercock, but this contradicts the account in Acts of a harmonious meeting of the apostolic council. St. Jerome, following Origen's lead, had argued that Peter engaged in one deliberate lie (he only pretended to reject the company of Gentiles) and Paul in two (he only pretended to condemn Peter, and his account to the Galatians was a falsehood to avoid annoying the Gentiles).<sup>19</sup> All of these were perpetrated in order to eliminate the Jewish restrictions on Christian eating habits. A contradiction in the Scriptures was looked upon as far more undesirable than a reputation for lying in the apostles whose activities they recorded.

<sup>19</sup> Cf. A. Harnack, *History of Dogma*, II, 367, n. 1.



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Actually, the Bible has no clear and consistent teaching on the question of falsehood explicitly, even though the spirit of the Wisdom literature in the Old Testament (especially Proverbs) and a couple of Pauline verses are clearly against it. Lying was a besetting sin from Jacob onwards. In the Commandments it is perjury which is forbidden, as we can see in the penalties provided in Deuteronomy 19:51, and calumny as well, to judge by Exodus 23:1. The passage in Leviticus 19:11, "Ye shall not steal, neither deal falsely, neither lie one to another," has to do with contracts and fair dealing in exchange matters. There is no outright condemnation of lying in the Beatitudes nor in the Sermon on the Mount, although the whole ethos of the Gospel is alien to lying. In the Fourth Gospel, the saying, "Ye shall know the truth, and the truth shall make you free" (8:32) refers to a particular truth about God. Paul establishes honesty as a sectarian or brotherhood virtue in Colossians 3:9: "Lie not to one another, seeing that you have put off the old man and his deeds." The story of Ananias and Sapphira (Acts 5:1-6) falls into this latter class. There *may* be a broader application in mind when St. Paul says, Ephesians 4:25, "Wherefore putting away lying, speak every man truth with his neighbor; for we are members one of another." In any case, deception has consistently been held (in the abstract) to be a fault against virtue, and no moralist has ever attempted to defend it *in principle*.

### *Is Ignorance Bliss?*

There are many ways by which a physician can deceive his patient, either by misrepresenting the facts as he sees them or by withholding them. Our opinion is that in either case such deceptions are morally speaking unlawful, being acts of theft because they keep from the patient what is rightfully his (the truth about himself), or acts of injustice because they deny to another what is his due as a free and

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responsible person. The most dramatic case of conscience in medical diagnosis and truth-telling has to do, of course, with the patient who is found to be the victim of a possibly or probably fatal disease, or one for whom no hope at all can be held out. In medical practice, as a matter of fact, there are many other diagnoses that entail sadness equal to or greater than the sadness that is caused by the malignant neoplasms; there are such conditions as brain damage in babies, leading to spastic paralysis, cardio-vascular diseases with poor prognosis, and the like. Yet even in terminal diseases the reaction of patients to the truth is varied and unpredictable. Dr. Fred C. Shattuck relates that one cancer patient, a cheerful businessman, never smiled again after he was told the truth, apparently crushed in spirit. But another patient, fretful and troublesome, who complained constantly at the discomfort, pulled himself together and showed great courage and moral vigor to the last.<sup>20</sup> Experienced pastors can tell of episodes wherein their own faith has been deepened by the faith and assurance and joy with which terminal patients faced death, sometimes over a long period, and in some cases *not until* they were made fully aware of the truth. But fear of the truth is very strong in many people, including physicians, and this fear accounts for the fact that from ancient to modern times no universal or local code of medical ethics has ever attempted to regulate the doctor's conscience in matters of truth-telling. The first code on the tablets of Hammurabi, 2080 B.C., said nothing about it; the confessors' manuals of the Middle Ages dealing with the rules of shriving surgeons and leechers said nothing; the latest code of the American Medical Association, by its silence or equivocation, leaves the whole thing up to the individual practitioner.

Suppose we turn for a moment to the opinion set forth by Dr. Richard C. Cabot, who was for so many years a physician and teacher at the Massachusetts General Hospital. As Pro-

<sup>20</sup> "Medical Ethics," address at Western Reserve College, Apr. 25, 1908.

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fessor of Social Ethics in Harvard University and Lecturer in Pastoral Care at Andover-Newton Theological School and at the Episcopal Theological School, Dr. Cabot followed his art and his conscience wherever they took him, into hospitals, laboratories, social agencies (he was President of the National Conference of Social Work), and into the labyrinth of morals. In the last of his books to be published (*Honesty*, in 1939) he included an enlightening chapter on "Honesty and Dishonesty in Medicine." After a long life of medical service and the most constant moral concern, he wrote: "As a young physician I tried the usual system of benevolent lying from 1893 to 1902. About that time a bitter experience convinced me that I could not be an amateur liar, an occasional, philanthropic liar in medicine or in any part of life. I swore off and have been on the water wagon of medical honesty ever since."<sup>21</sup>

In another work, written some years earlier (*The Meaning of Right and Wrong*), Dr. Cabot put the matter along these lines: "How can we ever be sure where a conscientious liar will draw the line? It appears to me, therefore, that the doctrine that it is sometimes right to lie can never be effectively asserted. For our hearers take notice, and so make ineffective our subsequent attempts to lie. I recall a sick man who ordered his physician never to tell him the truth in case he should be seriously ill. Picture the state of that sick man's mind when later he hears his physician's reassurances. 'Perhaps he really doesn't consider this sickness a serious one. Then he will be telling me the truth!' How can the sick man know? If he asks the doctor whether he considers the disease serious and gets a negative answer, how is he to interpret that answer? If the doctor did consider the disease serious he would also have to say 'No.' His words have become mere wind. No one can interpret them. His reassuring

<sup>21</sup> *Op.cit.*, pp. 134-156.



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manner, his smiles, his cheering tones may be true or they may be lies. Who can say?

"Suppose the disease comes to a point which demands operation. But to mention operation is to let the patient know that his trouble is serious, and that is forbidden. Shall the doctor therefore let the operation go and let the patient get worse? Whatever he does or says his patient has grounds for fearing the worst. No reassurance can be taken at its face value. The most trifling ailment must be suspect; good news may always mean bad.

"Here then is a self-enforcing moral law. 'Thou shalt not confess to a belief in occasional lies.'"<sup>22</sup>

Dr. Cabot then goes on to point out that if you *do not* admit that you tell conscientious lies, you make yourself an unconscientious liar. "For the very conscientiousness of conscientious lies depends on their being known to be exceptions to the rule. No one can be a universal conscientious liar." He was, in his own way, reaching the view put long ago in an old German proverb, *Wer einmal lügt dem glaubt man nicht, und wenn er auch die Wahrheit spricht* (he who once lies is never believed, even when he is telling the truth).<sup>23</sup>

A good example of the dilemma here is to be found in the newspapers of February 1923. The prize fighter J. J. Corbett had died of cancer, and *The New York Times* ran the story with this headline: "Ex-Champion Succumbs Here to Cancer. He Believed He Had Heart Disease." Such was the conscientious lie with which Gentlemen Jim's doctor had let him live out his last days. However, other doctors soon began violently to protest the open publication of the deception in a news story, one physician complaining to the editor that several of his own patients with heart diseases were wild with fear that they too really had cancer of the liver. G. K. Chesterton in his *Life of Browning* said, "Mrs.

<sup>22</sup> New York, 1933, pp. 167-168.

<sup>23</sup> Cf. a supporting opinion by Edith M. Stern, *McCall's Magazine*, Aug. 1951.

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Browning was surrounded by that most poisonous and degrading of all atmospheres, a medical atmosphere."<sup>24</sup> We can be thankful that great strides have been made in the past century towards humanizing the sick room and the hospital, but there will always be an element of degradation in it as long as sensitive and self-respecting patients have reason to suspect that they are being lied to by their medical servants, no matter how kindly the motives may be. Truth-telling is essential to any personal, thou-thou, relationship; just as essential as love, *agápe*, solicitude. The two go together, trust and truth; they require and presuppose each other. Paul's phrase (Ephesians 4:15), "speaking the truth in love," applies not only to our growth in Christ but to our growth in all relationships higher than *I-it*. On a broader scale in the body politic, it is vital to our whole democratic ideal. Government of, by, and for the people is only a myth unless it adheres to the principle that human beings act and respond on the basis of what they know, not on what is concealed from them. There is no responsibility once knowledge is denied or subject to cheating.

There is inescapably a subversive result of occasional lying. It makes no real difference whether it is perpetrated by a direct commission of an untruth, or indirectly through the omission of a truth. Lying troubles the waters of human relations and takes away the one element of mutual trust without which medical practice becomes a manipulation of bodies rather than the care of and for persons. The assumption made by the physician, when he has the *presumption* to withhold the truth, is that the patient is really no longer an adult, but rather either a child or an idiot, more an *it* than a *thou*. In this connection we should note that medical experience by no means lends support to the idea that telling the patient ominous truths will aggravate a serious condition. Some

<sup>24</sup> Quoted by R. C. Cabot, *Psychotherapy and Its Relation to Religion*, New York, 1908.



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years ago the Division of Cancer in the Massachusetts Department of Public Health issued a bulletin in which it was said, "The fallacious argument [that lies are necessary] may be answered as follows. . . . [We find that] those physicians and hospitals making a practice of telling the patients frankly when they have the disease, report only the fullest cooperation of the patient in his treatment. But the physician who lies to his patient denies him a chance to show his common sense and helps him one step nearer to the undertaker."<sup>25</sup>

Dr. Cabot, as we have seen, put forward a number of good reasons for truth-telling in medical care. In much of what he had to say he was answering a statement by Dr. Joseph Collins, who had defended medical falsehoods in *Harper's Magazine* for August 1927 in an article entitled "Should Doctors Tell the Truth?" Dr. Cabot pointed out, among other things, that without the truth patients will often object to decisive and costly forms of treatment, surgical or otherwise, since their urgency will not be apparent while the cost will be. If the patient is not told of approaching death, or at least of its grave possibility, he may fail to make proper preparation for his death in wills and testaments, or in reparations and restorations of one kind or another, or in reconciliations with God and/or men. Respect for the *rights* of a man whose time is running out is the real meaning of that famous petition in the Anglican litany: "From lightning and tempest . . . [plus a long list of other calamities] and from *sudden death*, good Lord, deliver me." It is not death itself that is the calamity, but its sudden coming.<sup>26</sup> Sudden death is the extreme fatality, and (as we have already observed) fatality is the denial and negation of morality. In the ethical perspective, fatality is nothing more nor less

<sup>25</sup> *Cancer Clinic Bulletin*, No. 41, Dec. 1936.

<sup>26</sup> I am indebted to a friend, a Roman Catholic moralist, who has pointed out to me that the Roman "Litany of the Saints" is even more explicit: "a subitanea et improvisa morte" (from a sudden and unprovided death).



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than willy nilly helplessness, being pushed around by circumstances in ignorance.

Furthermore, only a little experience with doctors, patients' families, and ministers of religion as they deal with terminal diseases or some other condition threatening death or helplessness is enough to show that a great deal of the time their evasion of the plain truth is a protective mechanism for themselves, a rationalization of their own embarrassment and dis-ease. Much of our human behavior, even among doctors, is aimed at satisfying our own needs, emotional and otherwise, not the needs of others. It is a fact to be faced that reservation or corruption of the truth is not always based on a genuine and maturely weighed decision that the patient "is just as well off if he (or she) doesn't know." Fear, we repeat, leads to lies. Fear and lies tend to require and presuppose each other, as do love and truth. Perhaps we need not feel so threatened emotionally by the truth. Dr. Walter Alvarez of the Mayo Clinic says, "often it is the relatives who have fear and mental pain. . . . In forty-odd years of practice I cannot remember anyone's committing suicide because I told him the hopeless truth. Instead hundreds of persons thanked me from their hearts and told me I had relieved their minds." Who are we to choose ignorance for others? We *have* to make the choice for animals, because they are animals, incapable of receiving or making creative use of such knowledge. But *ought* we to make it for men?

These considerations apply with just as much force to illnesses of the kind that are far from fatal. Even in imaginary illnesses of a neurasthenic nature, the common practice of the medical lie called "placebo" or the bread pill, the "pink water" or the "water subcut" (a pretended hypodermic), can be shown to undermine a truly moral relationship between physician and patient. A false pill of sugar, or something of the sort to deceive the patient into thinking he receives treatment or medication, is a self-defeating practice. In the first

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place, it is a deception, however well meant. In the second place, it is amazing how few good liars (to use a curious and contradictory phrase) there are, especially in such intimate relationships as illness and medical care. A good many doctors would be well advised, in the light of what we know nowadays about the dynamics of personal relationships, to rely instead, for supportive therapy and encouragement, upon a confident and genuine empathy. In the third place, these practices encourage the idea among neurotic patients that drugs will cure most ailments, and thus serve to extend the patent-medicine evil.

It may be pointed out, of course, that psychiatrists *on principle* do not in all cases share their diagnoses with the patient. Sometimes ignorance is bliss in correcting mental and emotional disorders. It might be claimed that something of the same therapeutic principle may apply to the general practitioner in his work. But for one thing we can answer that the cases are not parallel, inasmuch as the psychiatrist withholds his knowledge precisely because he may prevent the patient's recovery by revealing it, at least if he does so too soon. It is by no means evident that the same is true if the truth has to do with a pink pill for an imaginary illness, or with a diagnosis of cancer disguised to the patient as a tumor, or a heart disease camouflaged as overweight or indigestion. And in any case, the psychiatrist's ministrations are not even relevant in cases where imminent death or its probability is a chief reality factor, or in cases of primarily physical pathology, surgery, and the like.

There is no good reason, merely out of rigid adherence to abstract principle, to be hard or brutally logical about the morality of truth telling in illness and dying. On the other hand it seems fair to say that the right of the patient to know the truth is clear on moral grounds, and this is true whether or not our ultimate sanction for loyalty to truth and to personal rights is religious. Our argument would lose none

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of its force by accepting the non doctrinaire view reported in *The Journal of the American Medical Association*: "Some feel that a humanistic philosophy affords an adequate basis; some find in the teachings of Christ the highest concept of the meaning of a life of service."<sup>27</sup> Any sensitive person can sympathize with Dr. Alfred Worcester, who showed in the following plaintive remark that he recognized his duty to tell the truth yet disliked it: "Devotion to the truth does not always require the physician to voice his fears or tell his patient all he knows. But, after he had decided that the process of dying has actually begun, only in exceptional circumstances would a physician be justified in keeping to himself his opinion. In such cases his only question should be whether to tell the patient or the family, and, when both are to be told, which to tell first."<sup>28</sup> Dr. Worcester's surrender to conscience is questionable only insofar as, like St. Paul, who "kicked against the pricks," he tried to transfer his debt to his patient by farming it out to the family as middlemen or brokers.

### *The Medical Code on Lying*

The A.M.A. *Code of Ethics*, 1910, says (in Chapter Two): "A physician should give timely notice of dangerous manifestations of the disease to the friends of the patient." Nor, we should notice, to the patient himself! The Code goes on to say, still with patent uncertainty, that the doctor should "assure himself that the patient or his friends have such knowledge of the patient's condition as will serve the best interests of the patient and his family." It should be obvious that this is assuming much more knowledge of a family's affairs than medical care, as such, would normally provide. And again, how often the family's and the patient's idea

<sup>27</sup> "Factors Influencing Ethical Concepts and Ideals Among Medical Students," 113:1267-1270.

<sup>28</sup> "The Care of the Dying," *Physician and Patient*, Cambridge, 1929, p. 220.

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of the best interests at stake are not the same! How often by keeping the patient in ignorance precisely the opposite of what the patient would want has in fact come about, perhaps through a consequent failure to change a will, or to add a codicil, or to make some explanation to a loved one—all of these being things which only the patient could have done had he known the true state of affairs. It is also ironical to observe how often doctors and families are mistaken in supposing that the patient can be fooled by evasion and suppression of the truth. Dr. William H. Robey, in the George Washington Gay lecture of 1936, asserted that "the family is not to be fooled by any dissimulation."<sup>29</sup> Why, then, imagine that the patient is any easier to fool? Patients may sometimes be at a very low ebb and still show an almost preternatural awareness. If any self-possession at all remains, they are still persons with a person's right to know the truth. It is cruel and inhuman to leave them in doubt, suspicious and confused. Furthermore, it is an insult to be babied whether big or little issues are concerned. Dr. Weir Mitchell tells of once sending a colleague to see an old Quaker lady. Next time he saw her she said to him, "Never send that man to see me again. Thee knowest I do not like to have my feelings poulticed."<sup>30</sup>

A strange inconsistency is also to be found in the *Code of Ethics*. Following the equivocation we have already noted, it declares (Chapter Three, article three, section two) that in cases of medical consultation "all the physicians interested in the case should be frank and candid with the patient and his family." It is not at all clear why a medical consultant should thus be directly charged to be candid with the patient when the physician in charge is not. Yet even here the Code qualifies itself by remarking at another point that the consultant should "state the result of his study to the patient or

<sup>29</sup> *New England Journal of Med.*, 205:18, pp. 856-872.

<sup>30</sup> *Ibid.*

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his next friend in the presence of the physician in charge." And after all this temporizing about the doctor's obligation to tell the patient the truth, the Code ends with a Golden Rule of medicine, that the physician should "constantly behave towards others as he desires them to deal with him." But can it really be that doctors who practice professional deception would, if the roles were reversed, want to be coddled or deceived? If this is actually the moral standard of those practitioners who deny their patients the truth, then one can only marvel to find so many who are themselves willing, as the Quaker lady expressed it, to have their feeling "poulticed," and willing to be denied knowledge of the most decisive events of their lives, whether it is a fact of health or the final fact of death itself.

The tradition in Western civilization allows for what the law calls "privileged communications" between patient and physician, as between people and pastor. This, indeed, is one of the few priestly aspects of the doctor's role left over from the ancient times. What we tell our doctors and our clergymen is private, personal, our own; and in that sense, secret. Now, as it bears upon truth telling, the significant thing is that this ethical principle of the professional secret rests upon the conviction that knowledge of a person's private life gained in the course of professional services is a *trust*, the stewardly possession by a professional servant of what belongs to another. The secrets of the confessional box and pastor's study, and of the consulting room and clinic, *belong* to the person served, not to the priest or to the physician. They therefore have no *right* to pass them on to others *without the owner's consent*. By the nature of his office the priest has only that knowledge of a penitent's life which is already known to the penitent and shared by him with the priest. In the case of medicine, however, the physician, the diagnostician, gains knowledge of the patient which (in the nature of the case) the patient does not yet



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have. But it is still the patient's knowledge and information; it is his life and health which are at stake. The patient has "opened his books" to the doctor on the reasonable assumption that what is found there will be turned over to him, just as a business firm has a right to expect no deception or suppression from an auditor. In spite of all this, some doctors assume the god like power to ignore the propriety or proper ownership of the secret. On their own behalf they will insist upon the rule of privileged communication, expressing righteous indignation when others attempt to pry or extort information from them; at the same time, however, what they have refused others as not rightfully theirs to give, they will also deny to the patient himself, the rightful owner! Or, with a strange further confusion of ethical reasoning, they will deny the patient the truth which belongs to him, and then proceed to give it to his family or friends, regardless of the principle of professional secrecy.

Before we leave this subject of privileged communications, there is one more related problem of conscience to be faced. Must a doctor remain silent because of professional secrecy if a young man being treated for syphilis proposes to marry a girl who, according to the doctor's best belief, is ignorant of the fact? This is only an example, although a shocking one, of the general question whether professional confidences may be violated when the interests of "an innocent third party" are at stake. If we use the analogy of property rights again, as we have above in relation to the right of patients to know the truth about themselves, it seems fairly clear that in such a case doctors should "break the seal." Just as in property law and principle there is a rule of eminent domain, in which is expressed the conscience of the community that private property may be expropriated for the sake of a wider welfare of "innocent third parties," so the same qualification of rights, the same expropriation, applies to professional

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secrets.<sup>21</sup> Even in the most rigorous and exacting moral theology it is recognized that although secrets are obligatory, they can "be modified by the exigencies of public welfare."<sup>22</sup> Apart from secrets of the confessional (*secretum sacramentale, sigillum confessionis*), Catholic moralists allow what the Christian conscience has always provided for, that a legitimate lifting of the rule of secrecy "would be the case, for example, if an innocent man were to suffer serious injury unless a secret were disclosed" in order to prevent it.<sup>23</sup> This has been the position taken by civil courts in the English common law tradition. But surely, to go a step further in the reasoning here, we can question whether there is any good ethical ground for making an exception in the case of the seal of confession to a minister. Both the physician and the clergyman should be on the same footing in this regard. The same consideration of *charity* (the welfare of others) would apply to both professional secrets. The priest and his penitent are subject to the ethic of *agápe*, Christian love, which is a disinterested, self-denying love of neighbor. The physician is subject to eminent domain or the public welfare, and although these latter terms are not as idealistic in their connotations as *agápe* or "charity," they have the same force in practice. It would seem almost self-evident that, except for reasons of institutional expedience (such as creating confidence in the inviolability of the confessional "no matter what"), the argument that the *sigillum confessionis* is different because it is sacramental fails to hold any water. What kind of "sacrament" is it that can operate to deny Christian love, and make it of no effect?

Catholic moralists generally qualify the duty of doctors

<sup>21</sup> Cf. Joseph E. Maher, ed., *Christianity and Property*, Philadelphia, 1917, pp. 192-195. Thus Father F. J. Connell says, "the better theological opinion seems to be that in such circumstances the doctor may (and perhaps must) warn the girl, even though it involves the violation of the professional secret." *Morals in Politics and Professions*, *op.cit.*, p. 126.

<sup>22</sup> Koch-Preuss, St. Louis, 1925, v. 76.

<sup>23</sup> *Ibid.*, v. 77.

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to reveal professional secrets, and some would actually deny that any obligation at all exists in a case such as we have mentioned above. Father Regan allows that in such a case the obligation to protect the girl is a grave one, yet he insists that if the doctor can foresee that some "proportionately serious" harm will come to himself in fulfilling the "grave obligation" he may "excuse himself."<sup>34</sup> Father Slater dealt with an instance of the same kind, and came to the conclusion that the doctor should not reveal the truth, but that he should "counsel" the fiancé to postpone the marriage until cured (or not use the marriage rights until cured), or alternatively tell his bride-to-be the truth.<sup>35</sup> Yet this same writer also discusses the quandary of an English doctor whose patient, a railway signalman, suffers such severe asthmatic attacks that he blacks out altogether. He works alone in a signal box, regulating fast express passenger trains. At any time he may lose consciousness and let a train be wrecked. The doctor would like to warn the company, but his patient threatens to sue him for libel (libel in England being any damaging statement, such as one that would cause a man to lose his job, no matter how true it is). In this case Father Slater concludes that the secret *must* be disclosed, since "the rights of the public must be safeguarded, even at the expense of the individual."<sup>36</sup>

Now, what is the difference between a person's welfare, a single individual's claim upon a physician's charity, as in the case of the imperiled bride-to-be, and the public welfare, as in the case of the imperiled passengers? Perhaps for a utilitarian the difference would be in quantity or numbers, the good of a greater number. But that could hardly weigh as a factor with a Christian moralist whose concern for per-

<sup>34</sup> Robert Regan, "Professional Secrecy in the Light of Moral Principles," *Amer. Eccles. Rev.*, Feb. 1944, 110-147.

<sup>35</sup> Thomas Slater, S.J., "A Syphilitic Patient," *Cases of Conscience*, New York, 1911, I, 341.

<sup>36</sup> *Ibid.*, "A Puzzled Doctor," I, 339-340.

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sonality is such that "even the least of these" makes an imperious claim upon him. As long as "the innocent third party" principle applies, so that we may not resolve conflicts of interest at the expense of others, a professional seal will be broken to protect a single person as necessarily as to protect a number of persons. Father Slater could defend his discrimination, as between the fiancé and the signalman, only by having recourse to the reservation in Father Regan's opinion. He could maintain that the doctor in the first case would suffer a proportionately serious injury; that the injury to an innocent bride would be no greater than the doctor's loss of practice after an angry swain had denounced him for betraying the private affairs of his patients. In the second case, he would say that the injury to many passengers would far outweigh any loss suffered by a single doctor doing his duty to society, since it is better (as Caiaphas argued) "that one man should die for the people, that the whole nation perish not."<sup>37</sup> But this is only the utilitarian rule, the hedonistic calculus, in another form. Viewed within the context of the Gospel ethic, Father Slater's judgment in both cases is a preferential one, calculating and prudential compared to the disinterested love of neighbor in Jesus' teaching. It falls short even of the American Medical Association's code, a document which is by no means tied to as strenuous a moral standard as the Sermon on the Mount. The Code provides (1930, Chapter Two), "In such a case, the physician should act as he would desire another to act toward one of his own family under like circumstances." This is much closer to the Golden Rule of the highest Stoic morality.

Equivocal judgments like these have their source morally in what Catholics call the Rule of Double Effect, and in what Protestants call the lesser-of-two-evils doctrine.<sup>38</sup> It is

<sup>37</sup> John 11:50.

<sup>38</sup> The Rule of Double Effect is, of course, more carefully and fully worked out. A capsule statement of it by Thomas Slater, in *Cases of Conscience, op.cit.*, I, 26-27, is: "It is lawful to perform an action which produces two effects, one

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the same device in both schools of thought, whether it is used as a popular defense of the secular state's policies of war and power politics, or by an ecclesiastical historian excusing the behavior of the missionaries who sailed with Pizarro and Cortez. In all such affairs the evil committed (fully foreseen as a tragic or undesired consequence) is condoned by claiming that the good desired is at least proportionate to, if it does not overbalance, the evil. These moralists usually avail themselves of a semantic confusion. A closer examination will show that of the two evils between which they urge us to choose, one is *moral* evil (or sin) and the other is some *physical* or *social* evil (suffering). Now in Christian ethics, at least, one is not forbidden to suffer for the sake of his obedience to the claims of love, for doing good. This ethic certainly offers no advice to *weigh* the ethical satisfaction of acting virtuously against the costs or consequences of doing so, in some hedonistic scales balanced on self-regard and self-protection. On the contrary, the New Testament does indeed forbid us to commit sin (moral evil), and yet gives us no hope or expectation of avoiding unpleasant coincidences or consequences. The Christian ethic foresees that suffering (physical or mental evil) is apt to be a consequence of virtue; it assumes that loyalty to ethical principle costs us something.

### *Do People Want the Truth?*

By way of summary, we may say that in general we can validly assert our right as patients to know the medical facts about ourselves. Several reasons have been given for it, but perhaps the four fundamental ones are: first, that as persons our human, moral quality is taken away from us if we are denied whatever knowledge is available; second, that the

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good, the other bad, *provided* (1) the action in itself is good, or at least ethically indifferent; (2) the agent intends only the good effect, not the bad; (3) the good effect follows as immediately as (not by means of) the evil; (4) there is a sufficient weighty reason for permitting the evil effect."



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doctor is *entrusted* by us with what he learns, but the facts are ours, not his, and to deny them to us is to steal from us what is our own, not his; third, that the highest conception of the physician-patient relationship is a personalistic one, in the light of which we see that the fullest possibilities of medical treatment and cure in themselves depend upon mutual respect and confidence, as well as upon technical skill; and, fourth, that to deny a patient knowledge of the facts as to life and death is to assume responsibilities which cannot be carried out by anyone but the patient, with his own knowledge of his own affairs. On the negative side, we have reasoned that the common excuse given for deceiving the patient—"after all the doctors are fallible and make mistakes"—is not a valid excuse. In the first place, physicians are in conscience bound to indicate that they find pathological conditions and advise treatment only to the best of their knowledge and judgment, not with absolute certainty. In the second place, while the admission of human fallibility always qualifies any claims a doctor might make as to accuracy, *it does not qualify and cannot disqualify the obligation to be honest*. And, finally, we have rejected any distinction between lies (positive injuries to the truth) and concealment (merely negative failure to convey what is foreseen as prognosis and discovered by diagnosis). When moralists such as K. E. Kirk offer this distinction, condemning the former and justifying the latter, they have failed completely to grasp the foundation principles of the ethics of communication. We have argued, instead, that commission of untruth and suppression of truth are alike deprivations of a patient's right; and therefore theft, therefore unjust, therefore immoral.

The only remaining question is: what if the patient does not ask for the truth? This problem may arise either because he does not *want* the truth (perhaps out of fear, being threatened by what he suspects, or for some other reason),

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or because he does not realize that there is a truth not known to him but now discovered by the doctor. This problem, surely, cannot be regarded as a very difficult one in conscience. In the first case, when the patient has no desire to know the truth and the doctor has good reason to believe that the patient does not want to know it, the doctor should respect his wishes, even though it might well be a proper part of his role to help his patient to want the truth and to become able to accept it. It is no part of a doctor's duty to impose his diagnosis upon a patient or flout his wishes, unless, of course, he has reason to believe that he could not continue to treat the patient properly, according to the demands of the best medical care, without telling him. In such a case, surely, he should explain why he needs to tell (or at least that he feels obliged to tell), and if the patient still refuses to hear, then ask leave to withdraw from the case, urging that another physician be called in his place. In the second case, when the patient is too ignorant to ask for the information acquired by the doctor, it is clearly the doctor's moral obligation to supply it, together with an explanation of its meaning and importance. A person cannot refuse to return his neighbor's watch if he finds it, or at least to tell him where it is lying in the garden, merely because his neighbor does not know that he has lost it and has not asked the doctor if he found it or knows where it is.

Throughout this discussion of medical truth-telling our frame of reference has been physical rather than psychological diagnosis. A great many people naturally raise the question whether the reasoning here would be or could be applied equally to psychotherapy. In all probability it would not, and could not be without upsetting well tested principles of therapy. In the first place, genuinely psychotic patients fall into Jeremy Taylor's category of "children and idiots," as far as competence to seek or to receive the truth is concerned. If it is judged to be in their best interests,

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surely the truth about them ("their" truth) can be withheld in the same way that a minor's or dependent's property can be withheld and rationed by a parent or guardian. Yet, even in the case of people who are far from psychotic, suffering some much less pathological disorder such as emotional or personality problems, there is a further consideration that makes a great difference between the right to know the truth in their case, and a patient's who has come, for example, for advice in internal medicine. In the latter case the doctor discovers a truth which is factually perceived.<sup>39</sup> But in the case of psychiatric medicine and clinical psychology, apart from a physical analysis which may be related to it, the diagnosis is one of *evaluative judgment* about the patient's behavior and sentiments. However sound and wise the professional expert's diagnosis of behavior and motives and drives may be, it is, as far as honesty is at stake, in the area of *opinion*. Here, surely, the expert's obligation to tell the patient or client what is in or on his mind (i.e., the doctor's) is not as certain or compelling. He has formed an estimate of the patient and his problems; he has not learned a truth about him. The "truth" of his estimate still remains to be established, and probably cannot be established by any means other than exploratory and tentative therapy. Until it is established it is not a truth owed to the patient, as knowledge of glandular imbalance or low blood-pressure would be. Speaking of the psychological forms of illness and diagnosis, we may say with Carl R. Rogers, "In a very meaningful and accurate sense, therapy *is* diagnosis, and this diagnosis is a process which goes on in the experience of the client, rather than in the intellect of the clinician."<sup>40</sup>

Neither the spirit of rigorism nor of laxism has dominated

<sup>39</sup> This is asserted without ignoring what is involved in the general proposition that truth is a combination of fact *plus* interpretation.

<sup>40</sup> *Client-Centered Therapy*, Boston, 1951, p. 223.

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our discussion. It seems difficult, in the extreme, to imagine how a conference of medical men could take serious exception to it. If a seminar of physicians were to discuss, just for example, Immanuel Kant's ethical tract *On a supposed right to tell lies from benevolent motives*, and apply its reasoning to morals and medical care, we could fairly confidently expect them to come to much the same conclusion as we have.<sup>41</sup> We have looked into a subject too much avoided, using applications and reasons of our own, but the conclusion reached is by no means a new one, any more than the problem itself is new.

<sup>41</sup> They might not accept Kant's categorical imperatives, but as far as the point of truth is concerned they could transpose them all into hypothetical propositions without altering the course of the reasoning.

## The Non-Litigant Patient's Right to Medical Records: Medicine vs. Law\*

Donald G. Hagman<sup>1,2</sup>

Medicine and the law frequently take different views of the same problem but sometimes after extensive examination the views are more alike than a casual inspection would suggest. With respect to medical records, however, the two great professions have not yet reconciled their views, even in terms of learned and carefully considered discourse.

On a theoretical level, medicine v. law is an uneven contest. The law can compel performance. On the practical level, the medical view prevails; the law is neither sufficiently omnipresent nor rigorous enough in terms of sanctions to compel doctors and hospitals to practice what the legal view requires.

One major confrontation between law and medicine over medical records occurs when medical records become relevant to a lawsuit. While this matter will be given brief coverage later, (*vide infra*) the primary focus of this article is on the personal or property right of persons to obtain medical records—not because they are litigants or contemplate becoming litigants—but because they are or have been patients or stand in the shoes of patients as parents of minor children and representatives of deceased patients, etc.

This article will consider various aspects of the medical view of the non-litigant patient's right to the medical record, then the legal view, and conclude with some observations on rapprochement between the two professions in these matters.

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<sup>1,2</sup> Institute of Government and Public Affairs, University of California, Los Angeles.

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### The Medical View

In summary, the medical view is that patient medical records and the information on the records belong to the doctors or hospitals who prepare the records. Information from the records will be made available to others, particularly others in the medical profession, if the patient consents, but the patient or his representative is hardly ever entitled to have the record for his personal use, and he is not entitled to a copy or to have information from it.

The practice of keeping patients from their records is notorious. Even the courts notice it. For example, *Nishalow v. Horwald* (1) states "it is a matter of common knowledge that hospitals do not voluntarily make available their records to those contemplating legal action for malpractice, or to their counsel." When the patient in *Wheeler v. Barber* (2) wanted to see her consent form, "the hospital attendant allowed [her] to see her signature but kept the text of the document covered" (3).

Medical personnel, at seminars given as part of the research for this discussion in turn as part of the instructional program of the schools of Medicine and Law, UCLA and for Continuing Education in Medicine, UCLA Extension, in six California cities 1964-1966, agreed that it is a rare case when a patient is allowed to see his medical record. Patients are sometimes allowed to hand-carry their records, but not to read them.

The medical, clinical and legal views of medical personnel toward medical records were also tested empirically by three hypotheticals pretested by questionnaire or used in one or more of the seminars. After these preliminary tests, each hypothetical was also submitted by questionnaire to 100 doctors in California and 100 doctors in Minnesota.

In the first hypothetical a patient was attempting to obtain records to determine the identity of a doctor who negligently treated him. While the hypothetical involves a medical record possibly related to litigation, it was used to give an interesting context to the non-litigant patient's right to records.

The hypothetical indicated that: "P was a patient at a hospital and was injured due to the suspected negligence of one of the doctors. P does not know the identity of the doctor and seeks to look at his medical records

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at the hospital to see if they provide any clues. The hospital refuses to let P see his records."

Question: "Is the hospital justified in withholding the records?"

	Preliminary Questionnaire		Minnesota		California		Total	
	"Yes"	"No"	"Yes"	"No"	"Yes"	"No"	"Yes"	"No"
a) "medically?"	16	18	15	14	37	13	98	5
b) "legally?"	15	21	42	15	33	17	90	3
c) "legally?"	13	19	24	17	29	18	76	24

More than two out of three respondents thought there was no obligation medically to allow the patient to look at his records and a large majority thought that it was not required legally. The most frequent comments, and number of commentators were as follows: Attorney or physician should ask because of danger of misinterpretation of records — 9; subpoena necessary — 11; patient should be told identity of doctors but not given records to look at — 1; depends on how strongly negligence indicated — 5.

With respect to the comment suggesting willingness to disclose the identity of doctors, consider the following:

"It is well that [who delivered a baby and performed a circumcision that was properly not authorized] was only authorized to do surgical procedures as an assistant and there was no one supervising her at the time of the circumcision. Also, two days after the circumcision the mother denied to the mother that she delivered the baby.

After the father had been informed of the circumcision he telephoned various persons at the hospital in an effort to get information why it had been performed and who had done it, but was not successful."

In the second hypothetical, the patient asked his previous doctor to send copies of records to his new doctor.

Hypothetical: "P is treated by Dr. D for a broken arm. An X-ray was taken by the doctor, P paid for it, and the negatives are now in Dr. D's possession. P subsequently decides to go to another doctor and requests that the negatives or copies of them be sent to his new physician. P offers to pay for the cost of making copies. D refuses to deliver the negatives or copies."

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Question: "Should Dr. D be required to deliver the negatives or copies of them to P's new doctor?"

	Preliminary Questionnaire		Minnesota		California		Total	
	"Yes"	"No"	"Yes"	"No"	"Yes"	"No"	"Yes"	"No"
a) "medically?"	23	14	53	10	50	3	126	27
b) "ethically?"	26	11	54	9	49	4	129	24
c) "legally?"	14	15	37	23	37	15	83	53

There were no meaningful comments to the hypothetical that would explain the undeniably large number of "no" answers.

The respondents overwhelmingly indicated that the records should be sent as a medical and ethical matter, though a smaller majority indicated that it was necessary legally. There is no doubt ethically or medically that the record should be delivered to the new physician (5).

The third hypothetical concerned a patient who wanted a copy of his record for no particular reason and it was clear that he would not be harmed by receiving it.

Hypothetical: "A patient has a hernia operation. He is a bright, mentally balanced individual. The operation is a complete success. He comes to the doctor and asks for a photocopy of his medical record. He offers to pay."

Question: "Would withholding the copy be proper?"

	Bakersfield and San Diego Seminarists		Minnesota		California		Total	
	"Yes"	"No"	"Yes"	"No"	"Yes"	"No"	"Yes"	"No"
a) "medically?"	21	1	39	13	29	22	89	41
b) "ethically?"	23	0	33	20	30	21	91	41
c) "legally?"	16	3	25	13	24	23	75	44

The more frequent comments and the number of commentators were as follows: Record only given to another doctor, insurance company—11; patient should get summary but not actual record—5. A large majority of the seminarists and a smaller majority of the questionnaire respondents thought the doctor was not obliged to furnish the record.

The formal statement of medical ethics by the American Medical Association is in accord with the view that patients are not entitled to information from medical records: "The Judicial

Council does not believe that [medical ethics] intends or requires that a physician give a copy of his records to his patient" (5).

The reasons given for withholding the record are various. Some, as stated in Hayt and Hayt (6) or as discovered in empirical research are as follows:

1. The patient may alter the record.
2. Staff time is taken to find the record and explain it to patient.
3. The patient's doctor or some other doctor must pass on whether it is in the patient's interest to see the record.
4. The patient may notice that the record is incomplete, inaccurate or contains uncomplimentary remarks, all of which may result in embarrassment to medical institutions or personnel.
5. The patient has no right to the record. It is merely a means of communication among medical personnel.
6. Fear that the record may spark a malpractice or libel suit.
7. It is the hospital policy. "The medical record is the property of the hospital. The hospital has the right to refuse disclosure of the contents . . . to the patient . . . except in compliance with a subpoena" (7). "Because the record is the property of the hospital, the patient has no right to examine it. In a case where the patient or a member of his family or guardian desires to examine the record, the matter should be referred to the Medical Director and the attending physician" (8).
8. Furnishing the record could never do any good and might cause harm or upset the patient. For example, an entry of "patient sobb." might be construed by the patient to mean something else than that he had shortness of breath.
9. If a patient could see his record, the record might tend to include only what the patient would like to see. This would make it less reliable as a medical record.

#### Law

If there were nowhere else to turn, the matter of the non-litigant patient's right to his medical record would be one of first impression under the common law and statutory law of many states. In California, the answer might be determined on the basis of analogy and policy from other areas of the law.

For example, a patient attempting to secure his records might point out that the statutes and administrative code require hospitals to keep records. Doctors are not required to keep records but are required to make certain kinds of reports. The statutes also require that records be kept confidential. The statutes fur-

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ther indicate that a patient "owns" information in the record to the limited extent that the physician-patient privilege gives the patient control over the use in court of "information . . . transmitted between [the patient] and his physician . . ." (9) which includes information learned by examination and advice given by the doctor (10). In addition, "Whenever, prior to filing of any action, an attorney . . . presents a written authorization therefore, signed by a patient . . . [medical personnel] shall make . . . records . . . available for inspection and copying by such attorney . . ." (11). These kinds of provisions speak to a state interest in record management and to the use and availability of records with respect to lawsuits, but are at best inconclusively relevant to the determination of the non-litigating patient's right to see his records.

Perhaps it is all a matter of contract law. What the patient and the doctor and the hospital think about records becomes a term of the contractual relationship and determines who has the right of access to records.

Attorneys identified as legal counsel for the California Hospital Association state that a patient ordinarily has no right to see his medical record (12). They cite no authority. Perhaps they are only stating a hope.

The inference, analogies and theories from existing California law would not be of much help to the California court on the matter of access to records. Fortunately, while the cases can hardly be called numerous, there is law elsewhere in the country on the matter.

Cases from other jurisdictions make it clear that a patient is entitled to information from a record kept on him by a doctor or a hospital. The limitations are that the patient may be required to pay for the copy and it need not be given to him where it would not be in the best interests of the patient's health. There may be statutes in other states like Clean Air State's Ann § 4-104 which confer the right on a patient to inspect his records after discharge.

In the absence of any agreement between the patient and the doctor, the records themselves, that is, the paper, the ink, the X-ray negatives and the like are the property of the doctor (13). Hospital records are the property of the hospital (14). The patient, however, has a proprietary interest in the records them-



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selves (15), which allows him to inspect or obtain a copy of the record (16). The patient is the owner of the information constituting the record (17). It is not ordinarily necessary that the patient copy or inspect the record under the supervision of the record holder (18). While in *Y. Glace v. University Hospitals of Cleveland* (16) the court allowed inspection under supervision, prior to appeal (19) the hospital delivered copies of all the records to the patient and did not supervise inspection. The record holder probably has the right to charge the patient for a copy of his record (20).

If it would not be in the best interests of the patient's health to release the information from the record, the doctor or hospital can probably withhold it. For example, in *re Culbertson's Will* (21), held that it was against public policy to destroy a doctor's records, though his will ordered it. However, the court did not conclude that the records or copies of them should be delivered to the petitioning ex-patients. Rather, the court ordered the records be made available to the petitioner's new physician. While the court did not specifically so hold, the withholding from the petitioners is consistent with the theory that records should not be released prior to a determination that they are not contrary to the best interests of the patient.

Some courts require a clearance before denial would be proper (18), but others would give the record holder much greater discretion (22). Withholding the record while the patient was in a hospital or under treatment would probably be justified. Next to him have a right to information from the record in the event the patient dies (23).

Since the patient can get the information, he can authorize another, such as an insurance company, to copy and inspect his records (24). Despite the authorization, an insurance company may not be permitted to inspect records where it has unconditionally paid the patient's claim and therefore has no business reason to inspect the patient's record (25).

The common law generally encourages disclosure, unless adverse to the best interests of the patient. However, federal government regulations on the matter are somewhat less favorable to the patient. The standards established by the Veterans Administration may differ somewhat from the common law resolution of the problem (26). Copies are sometimes available to the

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patient without cost (27). If not without cost, a charge is made of 25 cents per photocopied page (28).

The veteran is limited to information concerning himself alone (29), and he may not be able to get information, even about himself, if the disclosure would reveal a confidential source of the information. Furthermore, if the patient wants the information just because he wants it, he may not get it. This may be inferred from the fact that the request for a copy of the record must indicate the purpose for which it is desired (30). Another provision, which may override other sections, suggests that the information may not be released unless it serves a useful purpose (31). Finally, next of kin may not have access to the information if it would cause repugnance or embarrassment to the patient (32).

The regulations of the Public Health Service, probably more influenced by the medical view on medical records (33), make it clear that the patient must show a need for the records. A patient might not get the records even though getting them would not be contrary to his best interests.

Upon a reasonable showing of the need therefor, the officer in charge of a hospital . . . may authorize disclosure to a patient . . . of such clinical information as such officer determines to be medically appropriate for disclosure . . . . If the patient's examination, treatment or care was requested or arranged for by a governmental agency, the information shall not in any event be disclosed without the consent of that agency (34).

Records may be released temporarily for purposes of examining or copying them (35), but "under no circumstances should the person inspecting the records be permitted to handle or inspect them without a representative of the Public Health Service being present in the room" (36). Certified copies of medical records can be obtained without a fee for the certification (37).

### Conforming the Medical View to the Legal View

An important reason that the medical profession persists in denying patients their records is the belief that this denial can be a self-help technique in defending malpractice cases. The medical profession simply does not believe that, except for privileged information, a medical record which contains evidence relevant to a lawsuit can almost always be obtained. Recently

enacted California statutes make the matter very clear (11, 28). To deny a patient access to his records on the belief that he will thereby be frustrated in bringing a lawsuit is a mistake. Ultimately, he can get them, so it may be wise to give the patient access unless that would not be in his best medical interest. The records available to the patient mean *all* his records. They might even include, for example, a defendant doctor's letter to his malpractice insurer indicating that he opposed (39). Statutes in some states, including California, do put limits on the patient's access to all use of reports of crime committees, hospital and medical society review committees, and morbidity and mortality studies (40).

Some in the medical profession are finally beginning to recognize the inadvisability of a policy of denying patients access to their records. For example, the policy of the American College of Radiology suggests that a liberal attitude regarding the release of films is more desirable than strict insistence on the right to require a court order before producing them (41). A lawyer who represents patients in malpractice claims has expressed a more cooperative attitude on the part of doctors and hospitals in recent years (42).

Nevertheless, the attitude as reflected by the medical profession in the hypothetical, when the patient wanted to determine who was the negligent doctor, persists. The only legal justification for withholding the records mentioned in the comments to the hypothetical is that the hospital might not have the sole right to the records and perhaps should inform the doctors involved before disclosing the contents of records. Further, the hospital should check with a doctor familiar with the case to determine whether the release of the records could cause the patient any material harm. Some of the comments to the hypothetical are largely related to these legal justifications, though the results are perhaps best explained by the almost neurotic unwillingness of medical personnel to let patients see the records. Medicine and the law do not disagree on restricting delivery of information on a record to someone else in the medical profession, as was reflected in answer to the hypothetical on that problem. There is no doubt that delivery would be required at law (43). Medicine and the law disagree again in the situation as contained in the hypothetical where a patient wants his

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record for some unexpressed purpose and it would not be contrary to the patient's best medical interest to have it. Of course, doctors and hospitals can and do discourage such access and anyone asking for a copy of his record is not likely to obtain it on a casual request. The doctor or hospital can even compel a patient to sue to enforce his right. The morality of forcing the suit to enforce the right is the same as that of a patient making the doctor or hospital sue to collect a legitimate medical bill.

While discussing the three hypotheticals, it is interesting to note that Minnesota doctors were consistently more hesitant about giving access to records than were California doctors. Perhaps this reflects a greater duplication on the part of California doctors who have repeatedly been subject to malpractice suits to an extent shared by doctors in few other areas. Perhaps California doctors, through more exposure to the law, have been persuaded that record withholding does not pay.

Most of the reasons for denying the patient access to his records that are previously listed are not persuasive. Modern copying devices eliminate the risk that patients will alter the record, and there is thus no need to watch a patient with a "hawk-eye" to make certain he does not alter the record. While some staff time may be involved in finding the record, the time involved should be minimal because open patient access to records is not likely to lead to wholesale requests for access. Moreover, medical records clerks do not have any obligation to take time to explain the record. Since patients should not have access to information on records that would be contrary to their best medical interests, the patient's doctor or some other doctor may have to take the time to look at a record before it is released. If large numbers of patients began requesting their records, such a burden on the scarce resource of medical talent in this country and elsewhere may well suggest that patient access to records should be restricted. However, the doctor would be justified in charging for this service, though even without charge it is unlikely massive numbers of patients would demand information from their records.

While patients may be shocked and dismayed by the incompleteness and inaccuracy of medical records, this is not a reason for denying access. Patient access to records may make it more rather than less likely that records will be better kept, even for

strictly medical purposes. Apparently, medicine needs a little reinforcement from the law.

One of the greatest problems in hospitals [is] getting members of the medical staff to write medical records as they should be written . . . . Not infrequently patients go to [the] operation without an adequate medical record (14).

If the medical record is primarily a means of communication among medical personnel, this is not to say that the public has no right to information from it. Fear that the record may spark a lawsuit is not a justifiable reason for denying a record, in fact, denial of access to a medical record often raises suspicions that had to underpin suits. The fact that it is hospital policy to not allow access to a record for denying access to records because the hospital does not have sufficient authority to make such a rule. So don't blame clerks are told never to give a patient his record, so they state that it is not available.

A more appropriate answer would be for clerks to tell patients that a doctor had to approve release of copies of records, that there would be a charge for the copies and for the delivery attendant on release of the records, but that upon approval by the doctor, copies could be obtained.

Of course, if denial of access to the record is because access would cause harm to the patient, then that should be denied access to whatever part would cause harm. This is a valid reason.

Finally, a reason offered for denying patient access to records is that medical personnel may then keep deliberately inaccurate records or deliberately omit items. The same argument can be and is made to keep records relevant to a lawsuit are discoverable. However, the participants in the seminars indicated that fear of lawsuits had a minimal effect on what went into medical records. Hopefully, this is true, but if it could be shown that the record or some part of it is not available for a lawsuit anyway, some temptation to distort the record could be removed.

No such showing could be made. Medical records are available for lawsuits. Availability for lawsuits means two things: (1) the material is relevant, and (2) right of discovery, whether or not information in the record would constitute admissible evidence. Relevant and competent evidence in the record is admissible at trial, unless privileged. Even the irrelevant and incompetent evidence in the record is discoverable, unless privi-



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leged. The probable availability of a privilege is remote. In many states there is no doctor-patient privilege, and where there is, it is subject to many exceptions. Therefore, doctors and hospitals must expect that if a medical record becomes relevant to a lawsuit, it will be available to the parties, the court, and the rest of the world.

To attempt to teach medical personnel which parts of the medical record would be inadmissible at a trial would be futile. Even a lawyer skilled in the rules of evidence would have great difficulty in identifying this evidence in advance.

First, the medical profession would have to be taught the hearsay rule. That rule is one of the most technical of the highly technical subject of evidence. It is almost impossible to say whether information in a record will be barred by the hearsay rule because it cannot be determined in advance for what purpose the information will be used. The hearsay rule bars admission only when the information is being offered as an assertion to show the truth of matters asserted therein. The fact that it is out of court (i. e., second hand) does not make it inadmissible for non-hearsay uses. Even if a hearsay use is being made of the information, there are numerous exceptions, many of which are of particular utility to the medical legal situation such as the exception for statements of present physical or mental condition and the exception for business (including hospital) records. A skillful lawyer can probably get any information he, for some purpose, despite the hearsay rule.

Second, the medical profession would have to be taught the opinion rule. The opinion rule is less technical than the hearsay rule, but almost any opinion that is properly in the medical record would also be accepted in evidence by the court. Opinions that have no medical reason to be in the record can therefore safely be made by and large because they may not be used in evidence. Of course, medical personnel will not trust such opinions in the record anyway.

Third, even if records or parts of them would not be available as evidence, they are generally discoverable. They are thus available for lawsuits.

While the law cannot inform medicine in advance what part of the record is safe from becoming relevant to a lawsuit, it can impose sanctions that make record manipulation risky. An

action may be brought for injuries that are proximately caused by inaccuracies in a medical record (45). While the court is sometimes tolerant of inaccurate and incomplete medical records this tolerance is rather surprising (46). Incomplete, inaccurate or altered medical records should, at minimum, be the subject of an admonition by the court. The court could thereby reinforce the medical community's duty to keep complete and accurate medical records, even long after the patient's death.

The courts are not always so concerned about insufficient medical records. For example, in the a mental patient's letter was found negligent in *Montgomery, et al. v. Bank & Trust Co. of Fargo v. U. S.* (47), and still in the case of a brother who was killed by the mentally ill father in *Adler v. Receiver, Allen v. Providence Hospital* reversed a directed verdict for the defendant hospital where the hospital's record accompanying a transferred patient stated "chest . . . and lungs negative" but the actual hospital records showed an advanced lung condition (48). Further, it did not help the defendant doctors in *Brown v. Moore* (49), when the court noted that records were inadequately kept and appeared to have been made after the event. In *Quintal v. Laurel Grove Hospital* (50), medical records on a temperature chart signed by the doctors the court listed as justifying an instruction *res ipsa loquitur* (51).

Statutes in a typical state may have many provisions concerning medical records. For example, in California,

"No medical certificate or other document directly or indirectly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts, constitutes the offense of falsification . . . (52)

that could lead to loss of a medical license. Prior to 1965 the statute covered only those certificates and documents required by law. An ordinary medical record may not have been covered. Certificates for three documents were directly referred to birth, death, certificate and medical reports and the like which could be used. The cases under the previous version of the law involved death certificates (53), and a certificate concerning syphilis (54). Certainly a medical record would now be covered. However, the requirement that the entry be knowingly false limits the efficacy of the statute as a means to assure accurate records.

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The accuracy of the record of drugs given is encouraged by a potentially more efficacious statute. It constitutes unprofessional conduct for a nurse to

falsify, or make grossly incorrect, grossly incomplete, or unintelligible entries in any hospital, patient, or other record pertaining to [any narcotic . . . or any dangerous drug] . . . . (55)

The list of narcotics (56) and dangerous drugs (57) is extensive.

The accuracy of the record of narcotics is assured in an additional manner. It is a misdemeanor (58) for a person to prepare, administer or dispense a narcotic without making a record containing the information required by statute (59). A drug can be prescribed by an entry on the chart or medical record of a patient registered in a hospital (60). Should a narcotic be prescribed but the medical record not be adequately prepared the doctor may have committed a misdemeanor. Conviction of a misdemeanor involving moral turpitude constitutes unprofessional conduct (61), though it is doubtful that less than a deliberate failure to make a record would constitute moral turpitude.

Forfeitures may delay the running of the statute of limitations. In *Mishalow v. Horwald*, the cause of death was not indicated on the medical record (62). The plaintiff therefore had no knowledge of the wrongful cause of death. Therefore, the anesthesiologist, who was being sued for malpractice, could not use the statute of limitations as a defense.

Criminal sanctions are applied to ensure the accuracy and availability of medical records that become relevant evidence in a lawsuit. It is a felony to offer in evidence as genuine or true any record known to have been forged or fraudulently altered (63). It is also a felony to prepare a false record knowing that it is to be produced at a trial as genuine or true (64). It is a misdemeanor to knowingly conceal or destroy any record to prevent its production at trial (65).

Finally, an alteration of a record can always be discovered by able counsel for the plaintiff and is almost always damaging when discovered. Defense counsel advises that records must never be altered (66).

In most cases, the availability of accurate medical records will not only be a great advantage to assist in the proper treatment

of the patient but will be a great advantage to the doctor or hospital involved in a lawsuit. The great disadvantage of the record may be lost when medical personnel are required to appear personally in court because the medical record is inadequate (57). Complete and accurate medical records are very important (58). Law and medicine agree on that point.

There is always an example of a "third" case that I cannot cite to support an argument that medical records should not be available. For example, medical records sometimes contain information furnished by third parties under an express or implied promise by the doctor that the information will not be revealed to the patient. The "third" case is where the doctor vitally needs some information about the patient, can get it from no one else and in order to get it is forced to reveal to the third party that the patient will never learn about it. The patient then demands information from the doctor and is told to see the record which contains the pertinent information. The best solution for the problem, of course, is that the doctor should not make such a promise. If he does and yet is forced to reveal, there is probably no remedy at law in the third party against the doctor. While he has breached a confidence, the doctor is no under fire of law. He has acted unethically (59). Moreover, it is not the patient's confidence that has been breached, and a doctor may not be ethically bound to keep a confidence that comes from the patient (60).

#### Conclusion

The law should be sensitive to the view of medical personnel on the right of patient access to medical records, so that an embargo is not imposed on medicine. Actually, the law will make information from the record available unless it is contrary to the best medical interest of the patient. Many in the medical profession do not apply this general rule, either in letter or spirit, though enlightened self-interest may dictate its observance. However, since the law generally allows a doctor to determine what is in the best medical interest of the patient, medicine should not expect greater leniency from the law.

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RECENT DECISIONS

1. 231 Cal Appd 507, 521, 41 Cal Rptr 805, 3-3 (1954).
2. 92 Cal Appd 776, 782, 238 P2d 68, 72 (1959).
3. See also *Rabin v. U. S.*, 232 F Supp 715 (C.D. Cal 1963).
4. *Noe v. Kaiser Foundation Hospitals*, 218 Ore 429, 435 12d 525, 599 (1967).
5. *California Medical Association, Legal Council Opinions and Reports* (1953) 1-7.
6. *Maytland Mayt, Legal Aspects of Medical Research* (1954).
7. *Consent Manual of the California Hospital Association* (8th ed 1957) Appendix I, p 1.
8. *Ibid.*, p 3.
9. Cal. Ev. C. § 992. See also Cal. Const. Art. I, § 27(b).
10. Cal. Ev. C. § 992.
11. Cal. Ev. C. § 1158.
12. *Fuller and McCabe, Disclosure of Medical Records: A Symposium*, *Hospitals*, July 16, 1957, reprinted in *Modern Hospital Association, Readings in Hospital Law* 137, 149 (1958).
13. *Reeves v. Pyramid Life Ins. Co.*, 50 F Supp 497 (D.C. 1943); *McGarry v. J. A. McFarlane Co.*, 272 Mich 591, 262 NW 206 (1935) noted 49 *Harv L Rev* 230 (1936); *Alchorn's, Inc. v. New Jersey State Board of Optometrists*, 65 A2d 614 (NJSC Ct Ch 1949) judgment modified on other grounds, 5 NJ 412, 72 A2d 873; *In re Collection's Will*, 57 Misc2d 291, 392 NY2d 366 (1963); *Fuller of Merchant Marine's Document Z 670982*, 1954 *Am Mar Cas* 703.
14. *Pyramid Life Ins. Co. v. Mercantile Hosp. Ass'n of Payson Co.*, 191 F Supp 51 (1961); *Wallace v. University Hospitals of Cleveland*, 82 Ohio L Abst 237, 161 NE2d 917 (1959).
15. *Bishop Clarkson Memorial Hospital v. Reserve Life Ins. Co.*, 230 F2d 1806 (8th Cir 1955); *Alchorn's, Inc. v. New Jersey State Board of Optometrists*, 65 A2d 614 (NJSC Ct Ch 1949) judgment modified on other grounds, 5 NJ 412, 72 A2d 873.
16. *Wallace v. University Hospitals of Cleveland*, 82 Ohio L Abst 237, 161 NE2d 917 (1959).
17. *Pyramid Life Ins. Co. v. Mercantile Hosp. Ass'n of Payson Co.*, 191 F Supp 51 (1961); *McGarry v. J. A. McFarlane Co.*, 272 Mich 591, 262 NW 206 (1935) noted 49 *Harv L Rev* 230 (1936).
18. *Bishop Clarkson Memorial Hospital v. Reserve Life Ins. Co.*, 230 F2d 1806 (8th Cir 1955).
19. 171 Ohio St 457, 172 NE2d 459 (1962).
20. *Wallace v. University Hospitals of Cleveland*, 82 Ohio L Abst 237, 161 NE2d 917 (1959) and 81 Ohio L Abst 234, 170 172d 261 (1959). Cf. *Fuller of Merchant Marine's Document Z 670982*, 1954 *Am Mar Cas* 703, *McGarry v. J. A. McFarlane Co.*, 272 Mich 591, 262 NW 206 (1935) noted 49 *Harv L Rev* 230 (1936).
21. *In re Collection's Will*, 57 Misc2d 291, 392 NY2d 366 (1963).





51. *Casper v. State Board of Public Health*, 102 C.I.App. 123, 239 P.2d 27 (1954).
52. Cal. Bus. & Prof. C. § 2602(e).
53. Cal. Hec. & Prof. C. § 11001.
54. Cal. Bus. & Prof. C. § 1211.
55. Cal. Hec. & Prof. C. § 11026.
56. Cal. Hec. & Prof. C. § 11025.
57. Cal. Hec. & Prof. C. § 4926.1.
58. Cal. Bus. & Prof. C. § 1213.
59. 131 Cal. App. 1317, 1 C.I.App. 3 (1954).
60. Cal. Pen. C. § 132.
61. Cal. Pen. C. § 134.
62. Cal. Pen. C. § 135.
63. *Memorandum of H. Gilbert Jones and Edith L. Jones, Conference on Medical Practices and the Law*, UCLA, D.C. 3, 4, 1956.
64. Letter of Robert E. Moore, Director, Division of Medical Regulation (Organization of the State Bar of California, 10, 1955) and California Medical Association and Dr. Schwartz, Physicians' 15, 16, 17, 18, 19, 20, 21, 22, 23 (1957).
65. *Chenoweth*, Legal Aspects of a "S. Case" 22-23 (1953); *Tong*, The California Medical Board 293 (1955).
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State Bar of California  
 1111 Wilshire Blvd., Los Angeles  
 16 Wilshire Ave.  
 Los Angeles, California 90024

*LAW of*

**HOSPITAL,  
PHYSICIAN  
and  
PATIENT**

*by* EMANUEL HAYT, LL.B.

Adjunct Associate Professor of Administrative Medicine, Columbia University  
Counsel, American Association of Nurse Anesthetists

Counsel Emeritus, Hospital Association of New York State and The Greater  
New York Hospital Association

Fellow (Hon.) of American College of Hospital Administrators

Fellow of American Academy of Forensic Sciences

Member of the New York Bar

General Counsel, Hayt, Hayt, Tolmach and Landau, Great Neck, New York

Trustee, Wyckoff Heights Hospital, Brooklyn, New York

LILLIAN R. HAYT, M.A., J.D.

of the New York Bar

AUGUST H. GROESCHEL, A.B., M.D., M.S., F.A.C.H.A.

Vice-President, The New York Hospital -- Cornell Medical Center

Assistant Professor of Public Health, Cornell University Medical College

Brigadier General, Medical Corps, Army of the United States (Ret.)

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nosis; condition on discharge; follow-up; and in case of death, autopsy findings.

## 2. THE HOSPITAL AS OWNER AND GUARDIAN OF RECORD

The medical record is the property of the hospital, but is kept for the benefit of the patient, the physician and the hospital. It serves as a tool for the physicians, the nurses and the other professional personnel, enabling them to have a detailed and current record of the patient's condition or progress.

After the patient has been discharged from the hospital, his medical record is carefully filed away where it can be available for future reference for any proper purpose for which it may be needed, whether in the patient's behalf or for the benefit of those who were concerned with his care. By its very nature, the patient's medical record is an instrument which concerns not only the patient but other persons as well. It must therefore be accessible to all those who have a legitimate interest in its contents.

### The Medical Record Librarian Is Custodian

The medical record librarian of the hospital is the custodian of records which contain professional secrets concerning patients. Such confidences have been respected both by civil and natural law since the time of the ancients. Hippocrates in his oath, dated about 450 B.C., pledges the physician to keep professional secrets inviolate. A modification of this oath is embodied in the pledge of the American Association of Medical Record Librarians, which states: "I pledge myself to give out no information concerning a patient from any clinical record placed in my charge, or from any other source, to any person whatsoever, except upon order from the Chief Executive Officers of the Institution which I may be serving."

The fact that there is, or is not, a medical record librarian in a hospital does not alter the basic obligations existing with reference to records between the patient, the physician and the hospital. In many states, the privacy of the record is protected by a privileged communications statute. Even where there is no statute, the patient has the right to insist that his medical record be kept confidential. In the absence of a waiver by the patient, the hospital has a definite duty to enforce such right. As a corollary, this right survives the patient's decease.

In hospitals, it is universally accepted as "standing orders" that the medical record librarian will furnish confidential information only on written authority of the patient, his guardian if he is a minor, his committee if he is insane or the representative of his estate if he is deceased. In cases where the patient is unconscious, delirious or seriously ill and cannot give permission for inspection of the record, and such information is essential to treatment or to procure some immediate benefit, the proper officer of the hospital may assume responsibility for the release. In such an emergency the law presumes implied authority.

### Release to Hospitals and Physicians

It is a usual practice for hospitals to release medical information to other hospitals or physicians caring for the patient without charging a fee. State statutes and hospital policies govern the release of medical information with or without a written authorization from the patient or legal guardian. There are hospitals that have adopted the policy that if a written request from a physician or another hospital definitely states that the patient is under their care, no written authorization is required from the patient unless the nature of the medical information contained within the medical record warrants the patient's authorization. Other hospitals require written authorization from the patient and also the consent of the attending physician before releasing any information from the hospital record.

When a request is received that states, "Send a copy of the chart," this type of a request can usually be interpreted as meaning to submit pertinent information regarding the positive diagnostic studies that established the diagnosis. It would be much easier if the persons requesting information could identify what they are particularly interested in receiving.

At the request of the patient, preferably in writing, reports should immediately be sent to the doctor then in charge of the patient. The diagnosis of the patient's ailment is paramount in arriving at the proper treatment to be rendered, and all information which aids the physician should be furnished so that proper treatment or advice can be given without delay. Whether the contents of the report are to be given to the patient rests with the decision of the doctor, who knows all the circumstances involved in the situation.<sup>2</sup>

<sup>2</sup>Hospitals, J.A.H.A., 38:31, March 16, 1964.

The petitioner, recently a patient in respondent's hospital, applied for an order directing respondent forthwith to deliver to the former's present physician certain x-rays of the petitioner, said to have been paid for by him, "for the purposes of comparison and other reasons connected with the treatment of the petitioner," said x-rays to be held by said physician for a period not exceeding thirty days. The other reasons were not disclosed.

The court said: "In the event of a malpractice suit against a physician or surgeon (or a hospital, for that matter) the x-ray negatives which he (it) has caused to be taken and preserved incident to treating the patient might often constitute the unimpeachable evidence which would fully justify the treatment of which the patient was complaining. . . ."

The application was granted to the extent that the respondent should afford petitioner's present physician access to the petitioner's entire medical record, as access to the said x-rays on its hospital premises under proper viewing conditions as often, within reason, as said physician elects to call during usual business hours within any thirty-day period agreed upon by the parties. The application was otherwise denied.

The court was not persuaded that a former patient under any circumstances has the absolute right to exclusive physical possession of a hospital's or physician's original medical records, in the broadest sense of those terms.<sup>3</sup>

#### Procedure for Corrections and Alterations

Removal of portions of a medical record is a serious thing, even if the purpose is to make certain corrections. The loss of the sheet or sheets may raise the inference that they were removed deliberately in order to suppress evidence. This may be true particularly in cases in which the physician is being sued for malpractice or when an action has been brought against the hospital in negligence. The attorney representing the patient will be quick to take advantage of the absence of the sheets by pointing out the inferences to the jury.

At times it becomes necessary for a physician, nurse or laboratory technician to make appropriate corrections in the record during or after a patient's hospitalization. Erasures may create curiosity, if not suspicion, as to the reasons for the change. It would be better

<sup>3</sup>Flaum v. Medical Arts Center Hospital, Sup. Ct., N.Y. Co., Sp. 1, *Chimera J., N.Y.L.J.*, Aug. 20, 1968, p. 2, col. 2.



practice therefore to make no erasures, but rather to line out the incorrect data with a single line in ink. The date of the lining out, the signature of the person doing it and the correct information should be added.

Sometimes a request to alter a record is complied with, not by actually changing the record, but by adding a notation at the end of the chart that the patient called at the hospital on a certain date and asked to have the record amended in certain particulars. Any explanation for the change in the facts will then fall upon the patient instead of the hospital.

In one case, the court ordered a diagnosis in a hospital record changed at the demand of the patient, who instituted an action for that purpose against the hospital. The court stated: "There can be no gainsaying the injustice resulting from the alleged erroneous diagnosis, as evidenced from the expert testimony of plaintiff's three eminent physicians, who unequivocally agreed in their testimony that the plaintiff was not suffering from schizophrenia in any form and was not a schizophrenic at the time he was in the hospital nor either prior thereto nor subsequent to his discharge therefrom, nor at the time of the trial before this court."

The court found that the correct and proper diagnoses of the plaintiff's condition at the time of his confinement was "Hysterical episode, resulting from a febrile and toxic infection," and the court "hereby directs that the hospital record so state without equivocation in place of the aforesaid erroneous diagnoses hereby directed to be expunged."<sup>4</sup>

### 3. GENERAL POLICIES FOR RELEASE OF INFORMATION

All information leaving the hospital based on the contents of the medical record should be controlled by a single person or agency. In the small hospital this person may be the medical record librarian. In the large institution, with the tremendous increase in hospital and medical insurance and consequent requests by third parties for information on which to determine the payment of insurance benefits, the issuance of medical information should be centralized in a Medical Information Bureau, operated best as a subdepartment under the direction and control of the Director of the Record Depart-

<sup>4</sup>Fleming v. City of New York, Sup. Ct., King Co. Special Term, Part III, Pette, J., N.Y.L.J., Dec. 15, 1967.

ment. Such an arrangement would facilitate not only the benefits payable to the patient but also the payments due directly to the hospital through assignments or direct payment provisions in the policies.

It may be desirable for the hospital to incorporate in the admission record a form of consent which will permit medical information to be forwarded to the employer, any physician, nursing service, welfare agency, or convalescent or nursing home or hospital appearing to have a legitimate interest and making inquiry.

#### **Information for Which No Authorization Is Needed**

No authorization from a patient is necessary to disclose ordinary facts unrelated to treatment, such as the number of times and the dates on which the physician attended a patient, that the patient was ill and was operated upon, the complete name of the patient, address at time of admission, verification of his hospital admission and discharge dates, name of relative or friend given on admission. However, discretion should be used and care taken to make certain that the inquiry is a proper one.

Any other information, including age, address on discharge, if to a sanitarium or state hospital, the service on which the patient was hospitalized and all professional information, particularly the diagnosis, should not be disclosed without proper authorization.

#### **Use by Hospital Medical Staff for Study and Research**

Members of the resident and attending medical staffs may freely consult such records as pertain to their work. Should there be any doubt in the mind of the medical records staff as to the purpose of viewing the record, access to the particular record may be refused and the matter referred to the administration for decision.

In its discretion, the administration may permit use of medical records for research purposes. Except for the house and visiting staffs, persons asking this privilege should secure the written authorization of the administration. When the record is used for research, it is not regarded as that of any individual but as a report involving the study of a disease or group of diseases.

Consent of the patient is not necessary when the record is used in the hospital for the common good. Should the record be sought for research purposes by one outside the hospital, a photostatic copy may be loaned until the study is completed.

Copies of medical records should be made with the specific approval of the administration. No member of the resident medical staff should issue any verbal or written information to persons outside the hospital organization without the written approval of the administration, except in the discussion of the progress of the case with relatives or friends.

#### **Private Attending Physician's Approval Not Controlling**

Hospital patient records fall into two groups: (1) those of service or ward patients, and (2) those of private and semiprivate patients. In the case of private and semiprivate cases, it is customary, at least in some hospitals, to obtain the approval of the attending physician to the release of information or for an examination of the record.

After a chart is filed, the attending physician has no legal right to determine who shall and who shall not see the record; his permission may be sought as a matter of courtesy. The attending physician of a private or semiprivate patient should know of a request to view the chart of the patient by an insurance representative, an attorney, another physician now treating the patient or other person properly authorized by the patient. If the attending physician declines to be concerned, the hospital should release the abstract even though there may be a claim contemplated or pending against another physician or the hospital.

The record librarian would do well to let the final decision in controverted cases rest with the administrator. Ordinarily, the administrator can refuse permission to any person, whether authorized by the patient or not, to inspect the record at the hospital. Whether such an attitude is justified under the particular circumstances must remain a matter for the sound discretion of the administrator. He may be arbitrary if he wishes, until he or the custodian of the record is served with a subpoena duces tecum or order for the production of the record in court or with some other valid legal process which relieves him of his discretionary authority in the case. In any event, the administrator need not act unless he is required to do so by competent legal direction.

#### **Requirement for Signed Authorization of Patient**

The hospital should procure a specimen signature of every patient before his discharge; his signature usually appears on the consent

for operation, patient's clothes list envelope or some other form. An actual specimen signature will enable the hospital to make comparison with the signature presented on a request authorizing the bearer to view the hospital chart, or an authorization for a copy or abstract of the record.

There is no legal requirement that the authorization of the patient be witnessed either by a notary public or other person. Comparison with the sample signature, which should indicate that the signature is that of the same person, is sufficient. The presence of a notary's signature and stamp or seal gives additional assurance that the authorization is bona fide.

#### Microfilming Medical Records

No known stated policies or regulations prohibit hospitals from removing medical records to another site for the purpose of microfilming them. This is done routinely by many hospitals throughout the country that employ outside firms to microfilm the hospital medical records. The microfilming company should be bonded to assure the safety of the records and the preservation of confidential information. The original medical record should not be destroyed until the medical record librarian or other person designated by the hospital has reviewed the microfilm for quality of film production and accuracy in microfilming.

X-rays are microfilmed to conserve space, to reduce fire hazards and to preserve in miniature infrequently used radiographs.

The clinical value of x-rays diminishes with the passage of time. Films do have a legal, a historical and an occasional clinical value after 10 years, but modern methods of photographic copying permit faithful microreproduction that will satisfy even the most critical radiologist.

The process of microfilming most widely used by hospitals today is the photographing of x-rays on 35 mm. fine-grain, high-resolving panchromatic film. From the processed negative as many positive prints can be made as desired and the print can be enlarged.

The hospital radiologist knows best what radiographs should be microfilmed and he should be consulted in making this decision.

Microfilming has some decided advantages: practically no space is required; records can be kept as long as the film withstands age and use; and, with a sophisticated system, there is no need to remove the film from the record room.

There are also disadvantages to microfilming: film may become spotted or deteriorate in time; reproduced prints are not always easily read; a unit record system is virtually impossible with roll film; and, researchers prefer to work with original charts.

Storage of original records also has both advantages and disadvantages. On the "plus" side, original records are more legible, and a unit record system can be maintained. Negative aspects are that records are a potential fire hazard, storage often is remote from the record room, and with indefinite storage (40 to 50 years) records yellow.

In addition to weighing these advantages and disadvantages, each hospital must make a critical policy decision before undertaking an economic analysis of microfilming versus storage of records. That decision is the number of years that records should and will be kept. This decision is based on answers to the following questions:

1. For how many years back are records useful in treating a patient? For medical research? For teaching? For nonmedical data in the chart?
2. How frequent are requests for charts that have been inactive for more than 5 years? 10 years? 20 years?
3. What are the state and local requirements regarding retention of medical records?

Ordinarily it is sufficient to retain only such basic information as dates of admission and discharge, name of responsible physician and record of diagnosis and operations in an index or on summary cards after 25 years. In some institutions, the minimum retention period is 10 years. Once the length of record retention has been determined, it is possible to apply a rather precise formula for evaluating the economics of microfilming medical records or expanding storage facilities.<sup>8</sup>

#### Policies for Releasing Information

It is recommended that each hospital have a well-defined policy regarding photocopies of reports that will recognize the legitimate interests of third parties while protecting the patient's right to privacy. The information to be released and the manner of releasing it must be determined by each hospital or group of hospitals in a locale.

<sup>8</sup>MacLeod and Vaughan, "Microfilm or Not?" *Hospitals*, J.A.H.A., 43:71, March 16, 1969.

Generally, it is economical and satisfactory to release information by standard insurance reporting forms or summaries or abstracts. When more information is needed, a duplicate copy of the discharge or pertinent parts of the record may be released. It is not desirable and usually not necessary to duplicate the entire record. The control of the record by the hospital is then lost, and the copy may be misused. Any portion of the record that is to be duplicated should be reviewed for possible misunderstanding of technical terms or abbreviations, or release of confidential or hearsay information.

Depending upon the nature of the request and the interests of the patient, the following are the recommended methods for releasing information, in the order of their desirability:

1. Standard reporting form;
2. Brief summary or discharge summary, or extracts of pertinent parts of the record;
3. Occasionally, a complete summary;
4. Rarely, a complete record.\*

#### Furnishing Abstracts of the Record

Attorneys and others having a legitimate interest in the medical record of a patient may be provided with an abstract of the record upon presentation of the authorization of the patient, or guardian in case of an infant, or the executor or administrator of the estate in case the patient is deceased, and on payment of the hospital's customary charge for such service. The hospital has the right to withhold such data as has no reference to the specific hospitalization, but the authorized inquirer may be advised of the other dates of hospitalization or treatment, if any; no further information need be given unless expressly authorized by the patient. In the case of a mental patient, or where the hospital deems the information to be of extraordinary character, the hospital in its judgment may refuse such abstract.

Before information is released on any patient, a checkup should be made with the accounting department to ascertain whether the patient's bill has been paid. If any balance is still due, it may be possible to arrange some form of security for payment, where it is

\*Hospitals, J.A.H.A., 39:16, June 1, 1965.



determined that money may be payable to the patient in connection with an insurance or other claim.

### Preparing Photostatic Copies of Record

When specifically authorized by the patient or his legal representative, such as his guardian or committee, the hospital may prepare or have prepared a photostatic copy of the record, the charge therefor to be paid to the hospital in advance, including a service fee if demanded. The person receiving the photostatic copy of the record should be requested to use it only for the purposes of the litigation and not to permit its examination by the patient or those who are not concerned in the litigation.

Photostated records may eliminate the need of the record librarian's appearance in court if both attorneys stipulate to the use of the photostatic copy in lieu of the original, or it may be used in evidence by statute. However, it is questionable whether a photostatic copy of a medical record should be available to persons not connected with the hospital; intimate details of the record may cause embarrassment to the patient, to physicians or nurses who have attended the patient, if given unrestricted circulation. Discretion should be used in each case to make certain that the information is not likely to be abused.

The court may issue an order directing that a record be produced and a photostatic copy be permitted to be made thereof as part of a record on appeal, in lieu of having the original subpoenaed on the argument of the appeal. No authorization of the patient is necessary, because the record is already in evidence, its admissibility having been passed upon at the trial. It is possible that the record was not admitted in evidence at the trial, but was marked merely as an exhibit for identification. In such case, the appellate court will probably pass upon the admissibility of the record. The court order must be complied with, irrespective of whether the record has been marked in evidence or for identification.

### Disclosure of Names of Physicians

The names of physicians and house officers associated with a case, while technically not privileged, should be considered as such; there is no legal compulsion to reveal the names except by court order, or in court. However, it is customary to disclose the names of attending physicians with their permission. Representatives of insurance carriers and attorneys for patients frequently are willing to pay the

physician a fair fee for his time in court. The hospital can create good will by acting as an intermediary for the physician rather than as a barrier against making contact with him for legitimate purposes. In any event, the physician should be notified of the request, as he may desire to get in touch with the inquirer.

#### Medical Information on Mental Patients

A mental patient who has been judicially adjudged to be an incompetent is represented by a person appointed by the court as a "committee." The committee acts in place and in behalf of the patient, and is authorized to do what the patient himself, if sane, could do. The authorization of the committee for the release of information is entitled to the same consideration as that of the patient.

When the patient is confined to a mental institution or hospital, the superintendent may be the one who was appointed as the committee. There should be no hesitancy in releasing information to the medical director or other head of a mental institution since the data will be for the patient's benefit.

#### Reports Required by Law

Where reports are required by law, such as births, or communicable or industrial diseases, the law prescribes the procedure to be followed and what information is to be disclosed; by its force as a statute it protects the hospital or physician against liability for disclosures.

#### 4. MEDICAL INFORMATION TO SPECIFIC INQUIRERS

An essential part of good public relations is the manner in which inquiries for information are handled in the hospital. Letters requesting reports should be answered promptly; inquirers should have explained to them the need for authorization. Knowledge of what type of information does not need the consent of the patient is also important.

Nothing is more discouraging to a caller at the hospital than to be sent to various departments, instead of to a central office. The person in the hospital whose responsibility it is to send out confidential or other medical information should be in a position to make a quick and intelligent decision as to what is required in the way of authorization and what data to release. The speedy processing of insurance

forms may avoid cases of financial hardship resulting from illness, disability, or death.

#### **To Patient or His Family**

It is natural for the patient and his family to be anxious about his condition. During the patient's stay in the hospital, inquiries should be directed to the attending physicians; nurses should restrict their opinions to general statements concerning the patient's condition; no prognosis should be given except by the physicians.

After the patient has been discharged, his signed permission should accompany any request for information concerning his hospitalization to be sent to a third party. At the patient's own request, information should be forwarded to his physician.

A complete detailed report of postmortem findings should not be sent directly to the patient's family; it should be forwarded to any physician requesting such information in behalf of the family. The findings are not considered confidential; however, they may be meaningless or confusing to a layman, and the information therefore should be placed in competent hands for interpretation.

#### **Examination of Record by Patient or Family Undesirable**

It is undesirable to allow a patient or his family to inspect his chart. He or they may find comments by nurses, interns or other members of the professional staff which may be considered complimentary or incorrect. The patient may then attempt to have the record changed, or cause annoyance to the administration or the professional staff. He may even bring a lawsuit for libel or some other fancied grievance. It is, therefore, advisable to have the abstract of the record omit characterizations or other remarks which may offend the patient.

In some states, as in Connecticut, a hospital, after the discharge of the patient, by statute must permit such patient or his physician or duly authorized attorney, upon request, to examine the hospital record, including the history, bedside notes, charts, pictures and films kept in connection with the treatment of such patient, and permit copies of such history, bedside notes and charts to be made by such patient, his physician or duly authorized attorney.

In some hospitals, when a former patient or a member of his family insists upon seeing the record, the following procedure is followed: The former patient (or his family) is advised that the record is the property of the hospital; that he has no right to it,

except as to information which may be needed by his physician in treating him, or by his attorney in representing him, in which cases the information ~~will be~~ given directly to the physician or attorney upon proper authorization. The patient is advised to consult his physician (private or staff) who took care of him for any information he may desire. If the physician is not available, the patient is given an appointment with a physician on the administrative staff of the hospital, who evaluates the inquiry and under appropriate circumstances provides the desired information to the patient together with a proper interpretation.

In one large general hospital, upon request of the next of kin or of the individual who gave consent for the autopsy, a brief letter of reply, stating simply the principal findings (diagnosis) at autopsy, is addressed to the inquirer over the signature of the physician who is medical director of the hospital or who is otherwise responsible for the release of medical information.

#### **Information for Physicians**

Outside physicians who make inquiries concerning patients should be referred to the administration; merely because the applicant is a physician gives him no more right than a nonphysician to see a patient's record, unless he is treating the patient or has the patient's authorization. Access may be allowed to a second attending physician, even over the objections of the original physician, if in the opinion of the administration such examination would be to the patient's benefit.

#### **Abstracts for Other Hospitals**

Abstracts, copies, and summaries may be supplied to referring physicians, hospitals, veterans' bureaus, sanitarium or similar institutions in charge of registered physicians, without an authorization from the patient. In case of transfer of a patient to any other hospital, sanitarium, nursing home or other institution under the direct charge of a physician, the patient should be accompanied by a sealed copy of the summary. When another hospital requests an abstract or a copy of the patient's history in whole or in part, the request may be deemed as coming from another attending physician.

#### **Authority of Governmental Agencies**

On request of a federal or state compensation commission, where it appears that a compensation claim is pending, information from

the records may be supplied and reports made on forms submitted by such agency, without the patient's authorization. Unless such reports are required by law, a governmental agency is not entitled to medical information without a patient's consent. The fact that the request comes from some governmental unit does not constitute a waiver. If such agency desires to view the record, a subpoena should be served on the hospital; at the designated time and place the patient or his attorney can voice objections, if any. It is to be remembered that the prohibition is against the disclosure of confidential information and not ordinary facts such as the name of the patient, his address, and the dates of admission and discharge.

#### Information for Social Agencies

Despite the fact that a social agency is one of recognized standing, it possesses no greater legal authority than any individual to demand medical information, without proper authorization. However, this rule is frequently ignored in the case of approved social agencies, where it is deemed for the welfare of the patient. Strictly speaking, the disclosure is not proper.

Verbal requests for information are to be discouraged in favor of written requests. The proper procedure for social agencies is to write to the social service department of the hospital.

#### Examination by Attorneys Representing Patients

Hospital records contain evidence which is important in litigation cases. The attorney is required to prepare a bill of particulars which indicates to the opposing side what he intends to prove at the trial as to the patient's injuries; he is restricted in his proof in court to what has been specifically claimed in the bill.

The chief objection to examination of the record by the attorney is that the names of the attending physicians may be obtained, and the doctors subpoenaed to court. Other objections to showing the records are the possibility of alteration and the necessity of having someone present while the record is being examined. Some administrators will sit down with the attorney and answer questions from the record.

If it appears that litigation is intended against the hospital, it is advisable to notify the liability insurance carrier and the hospital's attorney. If a specific physician is involved, he should be informed of the nature of the inquiry, as he may desire to report the matter

to his insurance company. Whether to give out information under such circumstances should be left to the discretion of the hospital's lawyer. When such information is refused, a subpoena or court order may require the hospital to produce the records for inspection.

In litigation between the patient and a third person in which the hospital is not involved, it would be well to require a subpoena or court order before producing the records in court. The records should remain in the custody of a representative of the hospital, and should not be withdrawn from his custody, unless directly ordered by the court.

An application was made to the Court of Claims for an order requiring the director of the state hospital to make accessible to the committee and his attorneys the hospital records of his ward and make a photostatic copy available at the applicant's expense. The purpose of the application was to ascertain the facts of an alleged accident on the hospital premises whereby the patient sustained physical injuries, so that the committee might ascertain whether a cause of action existed against the state or others. Necessary to the inquiry were the records of the patient's physical and mental condition and of the care, supervision and treatment given her.

"The right to examine necessarily implies the right to make notes or copies in aid of memory and for the purposes of subsequent study, consultation and analysis. Such a right is specifically provided in Section 324 of the Civil Practice Act relating to orders of discovery in actions. The omission of the Legislature to enact similar provisions to implement the right of examination conferred by the Mental Hygiene Law does not seem to us significant as respects the construction."

#### **Inspections by Defendants or Their Attorneys**

In most states with hospital lien laws, the statutes permit persons or corporations responsible for the injury to examine the records of the hospital pertaining to the injured patient. Ordinarily, the hospital requires the patient's consent before the chart may be inspected, but some lien laws do not make the patient's authorization a prerequisite.

The Delaware, Illinois, Maryland, New Jersey, New York, North Dakota, Oregon and Texas statutes state that the person or corpora-

<sup>1</sup>Matter of Bradshaw v. State of New York, 190 N.Y.S. 2d 894 (1958).



tion liable for the lien is entitled to examine the hospital records of treatment, care and maintenance in reference to the injured person. In Illinois, the hospital is required within ten days after it receives a written request to furnish to a party to the claim, or to file with the clerk of the court in which the action is pending, a statement of the nature and extent of the injuries and the history of the accident. Failure to comply therewith makes the lien null and void.

In New York State, however, examinations are restricted to items relating to the charges for treatment, care and maintenance; the patient's clinical chart containing the history, diagnosis and opinions of the physicians usually is not shown without the patient's permission. New York decisions have held that the lien statute does not repeal or modify the privilege against disclosure of confidential communications, but enables one liable for damages to examine the records for the purpose of checking upon the correctness and the reasonableness of the hospital charges.<sup>8</sup> Although the language of the statute is particularly broad, it was not intended to require a hospital to reveal confidential communications, nor is it necessary in order to determine the reasonableness of the hospital's charges to examine records as to the diagnosis of the ailment or disease of the patient. The hospital should furnish information in respect to the treatment, care and maintenance of the injured person without disclosure of confidential communications.<sup>9</sup>

The hospital lien law of the District of Columbia, which has a privileged communications statute, does not permit an examination of the patient's medical chart when a lien is filed by the hospital, but allows examination of the ledger entries and similar records of the hospital for the purpose of ascertaining the basis of such lien.<sup>10</sup>

Aside from any rights which may be given to attorneys for defendants or to insurance company representatives under the lien laws, there is no authority for the hospital to open the medical record of any patient to inspection without the patient's permission.

### Records of Retired and Deceased Physicians

Petitioners have brought proceedings to compel the delivery to them of certain personal medical records which allegedly were in the possession of the deceased as attending physician during his

<sup>8</sup>*Sanduce v. Mt. Sinai Hospital*, Sup. Ct., N.Y. Co., Sp. 1, Valente, J., *N.Y.L.J.* (Dec. 1941), p. 2070.

<sup>9</sup>*Matter of Larchmont Gables, Inc.*, 64 N.Y.S. 2d 623 (1946).

<sup>10</sup>Public Act 161, Code 38-301 to 395.

lifetime. In the alternative, petitioners have requested permission to examine and make copies of said records. The executor refused to deliver such records to the petitioners by reason of a clause in the will of the deceased providing as follows: "I direct my Executor, above mentioned, to burn and destroy all of my office records and files without opening or examining same."

The petitioners stated that they were long-time patients of the decedent, who conducted specific and general physical examinations of the petitioners and made periodic general examinations, including blood analysis, electrocardiograms, x-rays, etc. The petitioners further alleged that such examinations and tests were made with the intent and understanding that they would be recorded and would become part of their permanent record and as such would always be available to the petitioners.

In addition to legal requirements, there may be good reason why a physician would wish to preserve his records for some time. In many instances the patient must rely upon his physician and his physician's records in order to establish the fact that he did receive medical care and treatment or that he has had the services of a qualified doctor of medicine. Without the physician's records the physician who rendered the care would be unable to assist his patient. Thus, in the best interest of the patient, the physician should not indiscriminately dispose of his records but should give consideration to the type of practice he has and to possible needs of his patients.

From an ethical point of view a physician is under no obligation to turn his records over to his patients. In the best interest of the patient, however, when a physician contemplates moving from a community or retiring from practice, he might notify the patients on his active list of the fact that he intends to leave and encourage the patient to seek the services of some other doctor of medicine. The physician could also suggest that with the consent of the patient arrangements can be made to permit a succeeding physician, designated within a reasonable time by the patient, to review these records. In this way the patient's best interests may be served.

The court held that the executor should make available the records and notes pertaining to the petitioners to the succeeding physician of the petitioners upon the authorized request of the petitioners.<sup>11</sup>

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<sup>11</sup>In re Cuthbertson's will, 292 N.Y.S. 2d 806 (1968).

### Insurance Company Inquiries and Forms

An insurance company has the right, at least in Oklahoma, to inspect and copy hospital records of persons whose hospital or medical bills it has paid or is obligated to pay. If the company has a signed authorization from the patient or his representative, it has a right of access to the records without resort to litigation.

The hospital is the owner of the paper or other material on which the records are kept, "and not the owner of that information constituting the medical records of the patient. . . . The patient has a property right in the information appearing or portrayed on the records. . . ." With authorization from the patient, an insurance company has a legal interest in the information contained in the records for the purpose of determining its obligation to pay claims for hospital or medical services.<sup>12</sup>

Certain types of insurance policies are concerned with illness and injury to the person. There are accident and health policies, Blue Cross contracts, workmen's compensation insurance, products liability coverage, automobile and public liability, indemnity, hospital and medical malpractice protection and others. To facilitate prompt payment of bills, such information should be made available as readily as possible. The authorization should direct the specific hospital to release the information; a generally worded waiver attached to the insurance form or a photostatic copy thereof should be deemed sufficient.

It has been suggested that a code system be used in filling out certificates of proof of illness. The International Statistical Classification of Diseases, Injuries and Causes of Deaths was published in 1947, at Ottawa, as a project of the Interim Commission of the World Health Organization of the United Nations. Whether this classification or the "Standard Nomenclature" is used, a medical report in code, reaching only a medically trained person, would involve far less work to report and would limit the spread of the confidential information.<sup>13</sup>

Hospitals have had trouble with the multiplicity of questions on forms of various sizes and arrangements, and the inadequate space to answer questions. The American Hospital Association has recommended two general forms for use in all hospitals. The first form,

<sup>12</sup>Pyramid Life Insurance Co. v. Masonic Hospital Assn. of Payne Co., Okla., 191 F. Supp. 51 W.D. (Okla.) (1961).

<sup>13</sup>Margaret DuBois, M.D., "Why Not Medical Reports in Code?" *Hospitals*, 22:51, Dec. 1948.

approved by the Association's Board of Trustees in 1947, relates primarily to individually insured persons; the second, in 1949, to those covered by group insurance.<sup>14</sup>

### **Inquiries from Employers**

The fact that an employer has arranged for the hospitalization or has agreed to pay the hospital charges does not act as a waiver of the confidential relationship between the patient and the physician. No matter who arranges for the hospitalization or the medical service, he is entitled to no information from the case record except the dates of admission and discharge, without the patient's authorization.

Industrial companies frequently employ their own physician or operate their own clinic. It is permissible to transmit information confidentially to a company physician caring for a patient after hospital discharge, but such information is not the property of the personnel department or company management.

Sending unauthorized reports to employers or insurance carriers in cases not involving an industrial injury or disease is not permissible; however, where the state workmen's compensation act or unemployment insurance law requires a report, the necessary information is transmitted to the employer, insurance company or labor department in accordance with legal requirements, without the consent of the patient.

### **Information to Local Police**

Police cases involve accidents which are reported to the police department, or cases involving suspicion of the commission of crime. For police cases, the information for police records is automatically made available by hospitals. Special precautions must be taken in cases of suspected suicides, intoxication, drug addiction or moral turpitude, to avoid statements which may be considered slanderous or libelous.

### **Handling of Information for the Press**

It should be a matter of hospital policy for inquiries from newspapers regarding the condition of patients or other matters of hospital news to be referred to the director or to some person designated for the purpose.

<sup>14</sup>"Economy Through Uniform Insurance Report Forms," *Hospitals*, 23:49, Dec. 1949.

The hospital should not release information regarding a patient to the press or permit photographers to take pictures of patients without the written authorization of the patient and the attending doctor. Final consent rests with the patient, whose consent is sufficient, unless his condition is such as to preclude interviews or pictures without the approval of the attending doctor. It must be emphasized that good hospital administration and the best interests of the patient may sometimes bar pictures even when permission of the patient has been obtained. Sound judgment must govern such exceptions.

The hospital should confirm the presence of public figures unless expressly forbidden by the patient or his physician. Where there is widespread interest, a physician may arrange for periodic bulletins on the patient's condition.

#### Procedures for Answering Press Inquiries<sup>15</sup>

##### A. General Principles

1. The primary responsibility of the physicians and the hospital is the patient's welfare.
2. Newspapers exist for the common good and to bring matters of general interest quickly and correctly to the public.
3. The hospital has a responsibility to the patient, to the professional groups in its organization, and to the community.

##### B. Information to Be Given to the News Agencies

1. *Attending physician's name* may be given.
2. *A private patient's admission* may be acknowledged and the general condition stated.
3. *A ward patient's admission* may be acknowledged and the general condition stated.
4. *Emergency cases.* You may give name, age, address, occupation, sex, nature of accident, as automobile, explosion, shooting; extent of injuries such as injury to leg, arm, etc.; burns, wounds, and part of body. Be careful in expressing an opinion as to definitive diagnosis or prognosis.
5. *Restricted information.* In cases of poisoning, intoxication, stabbing, attempted suicide, or other similar occurrences, no

<sup>15</sup>Proposed by the Greater New York Hospital Association, Inc.

motive should be given. Medical information may be given only by physician in charge of case.

6. *Children.* Get consent of parent for release of medical information.
7. *Photographs.* None should be taken of unconscious patients. Permission of attending physician and patient is required in other cases. Permission of administrator or his designated representative is also required.

#### General Procedure

*One or more persons* should be designated specifically to handle press relations in the hospital. Since the administrator may be away from the hospital and cannot be reached, it is important that those persons designated to answer inquiries from the press be briefed thoroughly point by point as to hospital policy in answering inquiries.

*At least one person* authorized to answer inquiries from the press should be on duty at all times, especially on evening and night shifts.

*The names of such designated persons* should be made known to the telephone operators, admitting departments, information desk, nursing supervisors, emergency department, record department and to others who are likely to receive calls from newspapers or reporters.

*None other* than the designated persons may give information concerning patients to newspapers and reporters. All inquiries from these sources must be referred to the designated persons, who will always make the welfare of the patient their first consideration.

Information relative to *research and scientific projects* should not be made public without the consent of the individual involved nor in a manner to conflict with the ethics of the professional group concerned.

Information relative to the *activities of the hospital* should not be designed to secure comparative advantage over other hospitals or personal advancement of any individual.

At all times there must be *strict adherence to the truth*, unadulterated either by exaggeration or by incomplete and misleading statements.



Hospitals shall enlist the cooperation of the local medical society whenever indicated. These societies are governed by the principles of ethics of the American Medical Association. A conference committee of the hospitals and physicians can always adjust problems.



# HOSPITAL LAW MANUAL

HEALTH LAW CENTER  
WELLS FARGO CORPORATION

## MEDICAL RECORDS

Medical records are maintained by hospitals primarily to provide complete information about their patients. These records are compilations reflecting all the data necessary to the care and treatment of persons who are admitted. State licensing laws and the enforcing regulatory agencies are creating new and more stringent requirements with which the hospital must comply; in addition, non-governmental bodies, such as the Joint Commission on Accreditation of Hospitals, provide standards necessary to insure sound medical care. The maintenance of a medical records library and the formulation of accurate and complete medical records are regulated by both governmental and non-governmental agencies.

While many records are required to be maintained by hospitals, *e.g.*, financial records, vital statistics and those required under federal and state pharmacy and drug laws, and while many reports are required to be made, *e.g.*, those relating to communicable diseases, only those records relating directly to the care and treatment of patients will be discussed. The primary concern of this chapter will be the legal aspects of medical records, with particular emphasis on those records which are required to be kept and on the possibility of liability in those situations where information is disclosed extra-judicially.

### SECTION 1

#### RECORDS REQUIRED TO BE KEPT

##### 1-1 WHAT CONSTITUTES THE MEDICAL RECORD

The medical record is composed of at least two distinct parts—although these parts may be made up of several types of itemizations and forms. The first part can be called the information section of the record. It is compiled in the ordinary case upon admission; it details the pertinent particulars of the patient's history, such as name, age, reason for admission. The second part is the clinical section of the record, and this is a continuously maintained history of the treatment afforded the patient in the hospital. This part of the record reflects the results of physical examinations, the treatment administered, progress reports, physician's orders, clinical laboratory reports, x-ray reports, consultation reports, anesthesia record, operation record, signed consent forms, nurses' notes and the like.

The medical record, then, is a complete, up-to-date written record of the history, condition and treatment of the patient, and the results of his hospitalization.

May 1973

Medical Records 1

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## 1-2 LEGAL REQUIREMENTS

Hospitals are required to maintain records by a variety of statutes and regulations. In most states, under the public health laws, those who own, manage or supervise hospitals and other health facilities are required to make records of the personal and statistical particulars relating to their patients or inmates.<sup>1</sup> In some states those hospitals caring for the indigent sick are specifically required to maintain records pertaining to these persons.<sup>2</sup> But these requirements, like those relating to births, deaths, autopsies and the like, are promulgated primarily for statistical purposes.

The requirement that hospitals maintain medical records, that is, specific data relating to the care and treatment of patients, is ordinarily found in hospital licensing regulations. In the usual situation, the legislature gives plenary power to the regulatory agency to promulgate rules and regulations concerning hospitals.<sup>3</sup> These regulations generally set forth minimum record requirements. While several states specifically refer to medical records by statute,<sup>4</sup> only *Utah* has a provision which sets out detailed requirements concerning what medical records must be maintained and what the contents should be:

### § 26-15-58 LICENSES—MINIMUM REQUIREMENTS

\* \* \*

In order to qualify as a licensed hospital, the following minimum requirements must be met:

\* \* \*

(4) All tissues removed at surgery must be submitted for examination to a pathologist approved by the department [of health] and the pathologist's written report shall be made part of the permanent record of each patient operated upon.

(5) Each patient shall have a clinical record which shall include: detailed clinical history, description of physical examination, reports of laboratory tests and of pathology and X-ray examinations, admission (provisional) and pre-rogative diagnosis, clear description of treatments given, including all operative procedures, postoperative diagnosis, progress notes by the physician, final complete diagnosis, and results of treatment at the time of discharge from the hospital and other reports as specified by the depart-

<sup>1</sup> See e.g., N.Y. PUB. HEALTH LAW § 4165 (McKinney Supp. 1972-73); TEX. REV. CIV. STAT. ANN. art. 4477, Rule 50a (1966); FLA. STAT. ANN. § 382.31 (1960).

<sup>2</sup> E.g., DEL. CODE ANN. tit. 29, § 7202 (Supp. 1970).

<sup>3</sup> See e.g., MINN. STAT. ANN. § 144.56 (1970); ME. REV. STAT. ANN. tit. 22, § 1820 (1965).

<sup>4</sup> E.g., KY. REV. STAT. ANN. § 216.450 (23) (1972); MASS. GEN. LAWS ANN. c. 111, § 70 (1971).

ment in regulations. These records shall be properly indexed and filed in the hospital.<sup>5</sup>

Thus, generally, the requirements as to the maintenance and contents of medical records will be found in licensing rules and regulations. But even in these promulgations, the states are divided into three groups: those detailing the information required, those specifying the broad areas of information required, and those stating simply that the medical record shall be adequate, accurate or complete.<sup>6</sup> These regulations may also set out standards for the maintenance, handling, signing, filing and retention of medical records. The hospital should keep abreast of amendments and revisions to these regulations.

### 1-3 Retention of Records

It is clear that the hospital medical record is maintained primarily for the use of the hospital and the medical staff in providing better patient care, thus, the length of time a record should be retained should be determined on the basis of sound hospital and medical practice. However, the decision as to the period of record retention cannot be made on the basis of administrative and medical determinations alone. In several states, the regulations provide a specific length of time all records must be retained; in others, these specific provisions apply to certain records only, for example, x-rays. Several state regulations provide that the record must be kept permanently, while a few require that the records be kept for the period of limitations for contract or personal injury actions.

With reference to destruction of medical records, several states, by regulation, provide that records cannot be destroyed without the consent or approval of the regulatory agency. [For a discussion of the destruction of the original record when reproductions are made, see 1-4.]

In addition, some regulations provide that an "adequate permanent record" of each patient be kept. It is not clear that this language requires permanent retention, but it may be so interpreted. The *Virginia* licensing regulations provide, "Records shall be made for all patients and filed in an accessible manner with provision made for their safe storage." It is not clear whether the term "safe storage" affects the question of retention.

<sup>5</sup> UTAH CODE ANN. § 26-15-58 (1969).

<sup>6</sup> Arkansas, California, Colorado, Georgia, Idaho, Maryland, Massachusetts, Michigan, Nevada, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Washington, West Virginia, Wisconsin, Wyoming and Puerto Rico have detailed provisions. Alabama, Alaska, Florida, Illinois, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, Oregon, Rhode Island, South Dakota and Vermont specify broad areas. Arizona, Connecticut, Hawaii, Indiana, Iowa, Kentucky, Maine, Ohio and Virginia contain only a general statement.

Where there are regulations on the question, these will control. However, in the absence of regulatory requirements, each hospital must determine its own policy. It is clear that each record should be retained as long as there is a medical and administrative need for it; meaning a use for the records as a basis for later patient care, analysis, review and audit of professional and other hospital services. Whether the record should be retained beyond such medical and administrative need is difficult to determine.

It has often been suggested that a key factor to be considered is the statute of limitations on contract and tort actions. Retaining the record for this period would not impose a burden on the hospital medical record library, since this period of time is generally shorter than the period the record would be retained for medical reasons. If the period of the statute of limitations were used as a guide, in the case of a minor the record would have to be kept until the minor reached majority plus the period of the statute. While the possibility of an infant waiting until his majority before bringing suit is rare, it can happen.<sup>7</sup> However, it would seem, balancing all factors, that it is not necessary to retain records until some time after the minor reaches majority, and such a decision is not recommended. Most suits by minors will be brought soon after the accident causing the injury, if for no other reasons, because of the pressure of bills for care.

In the final analysis, no blanket rule can be devised. The length of time medical records should be retained after they are not needed for medical and administrative purposes should be determined by the hospital administration with the advice of counsel, taking into account all factors including whether or not microfilming is feasible or practical, available storage space, and the future need for such records, as well as the legal considerations of having the records available in the event of a suit by the patient against the hospital or a third party. It should be noted that there is no instance of hospital liability for failing to retain hospital records.

#### ¶ 1-4 Microfilming and other Processes

Where it is possible, the hospital might solve the retention problem by microfilming the records and destroying the original copies. This would reduce the need for storage space but might raise other administrative problems. The members of the medical staff, for example, might object to the restrictions on the availability of particular records for purposes of research and review.

<sup>7</sup> See *Bettigole v. Diener*, 210 Md. 537, 124 A. 2d 265 (1956), for a case involving this situation. See, however, *Hubach v. Cole*, 133 Ohio St. 137, 12 N.E. 2d 283 (1938).



Several regulations provide for microfilming or other photographic reproduction.<sup>8</sup> In some states specific authorization from the regulatory agency is required before the records may be destroyed; in these states hospitals should obtain whatever clearance is necessary before microfilming is begun.<sup>9</sup>

With reference to the question of admissibility, most states allow the use of photographic copies of business and public records as evidence. Unless a statute or regulation specifically prohibits it, microfilming may be employed by hospitals.

#### ¶ 1-5 Requirements Affecting the Medical Staff

Almost all licensing regulations impose a general requirement that records be accurate and complete. This requirement imposes a duty on the medical practitioner. In addition, the Joint Commission on Accreditation of Hospitals and several licensing regulations specifically require prompt completion of records after discharge of patients.

The *Connecticut* regulation reads:

Reg. 200. All hospitals . . . must comply with the requirements set forth in these regulations before a license is issued.

• • •  
1. Short-term Hospitals, a. General, and b. Special

• • •  
4. Medical Records

• • •  
(e) Medical records should be completed within fourteen days after discharge of the patient except in unusual circumstances which should be specified in the medical staff rules and regulations. Persistent failure by a physician to maintain proper records of his patients, promptly prepared and completed, should constitute grounds for suspending or withdrawing his medical staff privileges.

This requirement is made applicable to certain long-term hospitals by other provisions of the regulations. Other states have similar provisions specifically requiring the completion of medical records by practitioners within a reasonable length of time.<sup>10</sup>

Where these regulations exist, it is possible for a staff member to lose his privileges if there is persistent failure to keep records up-to-date. In *Board of*

<sup>8</sup> See e.g., ALA. CODE ANN. tit. 7, § 415(1) (1960); ARK. STAT. ANN. §§ 16-501 (Repl. Vol. 1968), 28-932 (Supp. 1971); CAL. EVID. CODE § 1550 (West 1966); see also regulations in Alaska, Indiana, Michigan, Missouri, Oregon, Pennsylvania, South Carolina, Tennessee.

<sup>9</sup> *Holly v. Bates*, 7 N.J. 191, 81 A. 2d 151 (1951).

<sup>10</sup> See e.g., the regulations in Alaska, Massachusetts, Minnesota, North Carolina, Texas, Wyoming.

*Trustees of Memorial Hospital v. Pratt*,<sup>11</sup> the Wyoming Supreme Court held that the hospital board had the power to suspend a physician who failed to abide by the medical staff rule requiring records to be kept up-to-date.

Almost all regulations require that the practitioner sign the record. Some require that all orders be signed, while others merely refer to the signing of the completed record. In any event, the duty is imposed upon the member of the medical staff who attends the patient. Both the completion and signature requirements should be incorporated in the rules and bylaws of the hospital or the medical staff.

Another regulation affecting the medical staff requires inclusion in the medical records of the pathologist's reports on tissues removed in operations. Several regulations have this requirement; some with a requirement in general terms stating that special examinations and laboratory findings be included in the record. Other states provide specifically that the tissue report of the pathologist is to be made a part of the patient's record. [§ 245] For a statute so providing, see *Utah* provision at ¶ 1-2.] If this report is part of the record it will be subject to examination and may be admissible in evidence.<sup>12</sup>

A related question which has arisen is whether the report of the tissue committee of the medical staff is subject to examination. This report is not a medical record, but it may relate to the care and treatment of an individual patient. In *Judd v. Park Avenue Hospital*,<sup>13</sup> a patient sought to subpoena the records of "any and all medical staff discussions and meetings of committees" relative to the surgery performed upon him. The court refused to allow the subpoena. It held that the statements were hearsay; such reports were distinguished from entries in the patient's records made contemporaneously with his treatment. The patient also sought to examine entries in the surgical log book and entries in the operations records and disease index cards relating to surgery performed by the defendant physicians, prior to the time of plaintiff's treatment. The court held that only those entries in the surgical log book relating to treatment of the plaintiff could be examined and that the entries in the operations records and disease index could not be examined because they were privileged information relating to the treatment of other patients.

On the other hand, in *Kenney v. Superior Court*,<sup>14</sup> a patient was allowed to subpoena the records of a hospital relating to the defendant physician. The

<sup>11</sup> 72 Wyo. 120, 262 P. 2d 682 (1953); see *Bryant v. City of Lakeland*, 158 Fla. 151, 28 So. 2d 106 (1946).

<sup>12</sup> For examples of the use of tissue reports in trials, see *Valdez v. Percy*, 35 Cal. App. 2d 485, 96 P. 2d 142 (1939); *Riggs v. Gouldner*, 150 Kan. 727, 96 P. 2d 694 (1939).

<sup>13</sup> 37 Misc. 2d 614, 235 N.Y.S. 2d 843, *affirmed* ..... A.D. 2d ..... 235 N.Y.S. 2d 1023 (1962).

<sup>14</sup> 255 Cal. App. 2d 106, 63 Cal. Rptr. 84 (1967).

records sought by the plaintiff dealt with disciplinary proceedings, if any, concerning the physician, his status on the hospital staff and any indication of his removal from the staff. The trial court ordered the production of those records because they might have discovery value and might assist the plaintiff in his preparation for trial. The appellate court agreed stating:

Records of disciplinary proceedings, or of the status of a doctor on a hospital staff, or of his removal therefrom, may or may not be admissible evidence. Even if inadmissible such records may very well point the way to evidence admissible in a medical malpractice action.<sup>15</sup>

The court also required the defendant to answer certain interrogatories with reference to any facts indicating whether or not he had conferred with experts pertaining to any facts dealing with the medical care, treatment, prognosis, diagnosis, etc., of the plaintiff. In the event of an affirmative answer, the interrogatory required the disclosure of the names, addresses, and specialties of such experts and the dates of contact. The defendant was also asked to disclose whether or not any experts were to be called as witnesses and if so, the same information regarding them was sought. The appellate court ruled that the question relating to the conference with experts pertaining to the facts and statistical information about the patient, as well as the names, addresses and specialization of such experts, was proper and had to be answered. The court also held that the defendant had to disclose the names of any witnesses he intended to call.

Finally, the defendant was asked to disclose whether the factors relating to the case had been presented to a medical committee, and if so, to disclose the dates and places of conferences, names, addresses and telephone numbers and type or class of doctors that were on the committee. The court held that the defendant was not required to disclose the requested information about the medical committee. It said that requiring this disclosure would be a violation of the attorney's "work product" privilege.

In the *Kenney* case it is of interest to note that there was a standing hospital rule against the release of records without a court order. Thus, the plaintiff, in addition to presenting sufficient information in the court to justify the issuance of the subpoena, also claimed that he had no access to any of the information while the defendant would either have access to the records or would have knowledge of its contents. More importantly, the *Kenney* case points to a trend on the part of the courts to allow discovery of not only admissible evidence but also information which will enable a party to prepare for trial effectively. Other cases highlight this trend.

<sup>15</sup> *Id.* 53 Cal. Rptr. at 37.

In *Myers v. St. Francis Hospital*,<sup>16</sup> plaintiff brought a malpractice action against a hospital and a physician for an allegedly negligent blood exchange transfusion administered to an infant. An interlocutory order was entered directing defendant physician to answer certain interrogatories. On appeal by the physician the court held that it was proper and relevant to inquire of the defendant what he did and why, and what happened in the course of, or as a result of, the procedures he followed. Moreover, the plaintiff was held to be entitled to have answers to his questions concerning the physician's qualifications, experience and treatment in similar cases.

The *New Jersey* court in this case stressed the fact that the applicable procedural rules permitting discovery of any matter not privileged which is relevant to the subject matter of the pending action or is reasonably calculated to lead to the discovery of admissible evidence, were designed to encourage full discovery of all matters not irrelevant or privileged. Thus, questions relating to the physician's license, education and internship, training and experience in a specialty, hospital connections, teaching, membership in medical societies, writings, and occasions on which he performed similar treatments (as well as the names, addresses, dates and factual accounts of every patient for whom he performed a similar procedure) had to be answered. The court said this information related to the physician's qualification and experience and were proper matters for cross-examination.

However, the fact that names and addresses of a physician's former patients and details regarding their treatment may be relevant to the issue of negligence or competency in a malpractice suit does not necessarily render such information subject to discovery by the plaintiff. In *Williams v. Thomas Jefferson University*,<sup>17</sup> the court refused to require the defendant hospital to answer interrogatories seeking information about women on whom therapeutic abortions had been performed, so that plaintiff could direct inquiries to them for the purpose of obtaining evidence to impeach the credibility of the defendant physician. The court recognized this information as being privileged, stating that the performance of an abortion is an extremely personal thing to each woman who has undergone such a procedure, a fact which she may wish to conceal from others. "A collateral attack for impeachment purposes does not weigh very heavily in a balancing of interests when opposed to such obvious reasons for privacy."<sup>18</sup> [REDACTED] For a detailed discussion of the individual's right to be protected from this type of invasion, see ¶ 2-5.]

A growing majority of courts that have spoken on this question have otherwise allowed plaintiffs in malpractice actions quite liberal discovery. If the

<sup>16</sup> 91 N.J. Super. 377, 220 A. 2d 693 (1966).

<sup>17</sup> 343 F. Supp. 1131 (E.D. Pa. 1972).

<sup>18</sup> *Id.* at 1132.

plaintiff can show that the information sought is relevant to the subject matter or reasonably calculated to lead to the discovery of admissible evidence, he is on solid ground. There is a recognition by the courts of the plaintiff's difficulty in discovering evidence in a malpractice action. Relevant facts and information are more likely than not in the sole possession of the physician and his colleagues or in hospital records other than patient medical records.

Under modern statutes and court rules, private documents of many types are subject to discovery and examination prior to trial, so long as it can be shown that they are pertinent and material to the issues in the case. As the *Kenney* and *Myers* cases show, information from private documents, such as hospital records, can be discovered not only when they relate to the issues in the case, but also when they are relevant to the subject matter and will assist the party in his preparation for trial. Even where documents are specifically made inadmissible, they may still be subject to discovery so long as such discovery will not constitute an invasion of another's right to privacy.

A California statute, for example, provides that the written records of interviews, reports, statements or memoranda of in-hospital medical staff committees relating to research and medical studies for the purpose of reducing morbidity or mortality are not admissible in evidence. The statute further provides that the disclosure, with or without the consent of the patient, of information concerning him to such in-hospital medical staff committees does not make unprivileged information which would otherwise be privileged. These data are, however, subject to discovery proceedings, except that the identity of any patient may not be discovered unless the patient consents to such disclosure. The admissibility into evidence of the original medical records of any patient is not affected by this act.<sup>19</sup>

## 1-6 LIABILITIES

Various state regulatory agencies in the field of public health are given the power to promulgate rules and regulations which govern the operation of hospitals. Not the least of these is the power to grant or deny a hospital license in the first instance. In addition, these agencies may exercise continual supervision over hospital operations, and may suspend or revoke licenses previously granted.<sup>20</sup>

While the approach of these agencies in the past has been generally one of education and gradual improvement through conciliation, in some instances of substandard operation and refusal to comply with minimum requirements, the police power has been used to revoke hospital licenses. This power may be

<sup>19</sup> CAL. EVID. CODE § 1156 (West 1966).

<sup>20</sup> See e.g., UTAH CODE ANN. § 26-15-60 (Supp. 1971).

exercised on both the state and local levels.<sup>21</sup> The enactment of stricter laws and the promulgation of regulations with higher standards may lead to more stringent regulation and tighter enforcement.<sup>22</sup>

It is not suggested that the hospital's failure to comply with minimum standards relating to medical records will, standing alone, cause a revocation of license or accreditation, but this failure, when coupled with others may produce such a result.

In addition to the liabilities which may arise because of noncompliance with statutory and regulatory standards, hospitals may be held liable for the breach of a duty to maintain accurate records.

In *Hansch v. Hackett*,<sup>23</sup> a wrongful death action, the hospital was held liable for an attending nurse's failure to observe the symptoms of eclampsia and her failure to record them on the patient's chart. The court stated that the symptoms were such as should be observed by a nurse even though she might not have known what was indicated. If the information had been available the doctor might have ordered the proper and necessary treatment.

In *Aberson v. City of New York*,<sup>24</sup> the injured plaintiff was x-rayed at a city hospital. A doctor read the wet film and told plaintiff that there was no fracture; he advised her to take hot baths. On the next day the roentgenologist reviewed the dry films and found a fracture. The change in diagnosis was noted on the patient's record, however, it was not communicated to the patient. Testimony indicated that the procedure in cases of this nature was for the deputy superintendent to be informed of the discrepancy and for him either to notify the patient or arrange for immediate hospitalization. In this case nothing was done, and the patient suffered damage. The court held the hospital liable based on its breach of an administrative duty:

In the case at bar, the doctors had performed their duty,—good or bad. A notation was made on the patient's record of a change in diagnosis. Either a clerk failed to bring this to the attention of the deputy superintendent or the deputy superintendent failed to notify the patient of the change, either by phone, police or ambulance service. This omission constituted an omission in the performance of an administrative act and the hospital is liable in damages therefor.<sup>25</sup>

<sup>21</sup> *Spears Free Clinic & Hospital for Poor Children v. State Board of Health*, 122 Colo. 147, 220 P. 2d 872 (1950).

<sup>22</sup> See N.Y. PUB. HEALTH LAW §§ 2800 to 2810 (McKinney Supp. 1972-73); *Munzer v. Blaisdell*, 183 Misc. 773, 49 N.Y.S. 2d 915 (1944).

<sup>23</sup> 190 Wash. 97, 66 P. 2d 1129 (1937). See also *Larrimore v. Homeopathic Hospital Association of Delaware*, 54 Del. 449, 181 A. 2d 573 (1962).

<sup>24</sup> 205 Misc. 727, 132 N.Y.S. 2d 357 (1954).

<sup>25</sup> *Id.* at 729, 132 N.Y.S. 2d at 359.



In another case arising in *New York*, a plaintiff failed in an attempt to impose liability on a hospital for alleged damages sustained as a result of errors and inaccuracies in the medical record.<sup>26</sup>

A possible sanction, although not a legal one, is the denial or revocation of accreditation by the Joint Commission on Accreditation of Hospitals, if medical records do not meet the standards established by that body.<sup>27</sup> Failure to obtain accreditation or loss thereof, may adversely affect other aspects of hospital operation.

## SECTION 2

### OUT OF COURT DISCLOSURE OF MEDICAL RECORDS

When disclosure of information contained in a medical record is sought in a non-judicial setting, several problems arise. While the determination as to when and how this information is to be released or disclosed is primarily an administrative one, legal considerations arise. There is very little authority upon which to base legal answers. This section will not deal with those situations in which some form of legal authority is invoked to procure the record or information contained therein. Thus, subpoenas from courts or quasi-judicial bodies to medical records librarians will not be discussed, nor will disclosure to authorized persons pursuant to workmen's compensation or hospital lien laws be treated. This section will deal with those circumstances under which the hospital may release or refuse to release the medical record or information contained therein.

#### 2-1 OWNERSHIP AND CONTROL OF THE RECORD

The records of the hospital, including the medical records, are the property of the hospital.<sup>28</sup> In some states regulations are found to this effect. The *Missouri* regulation pertaining to ownership and control provides:

##### B. HOSPITAL RECORDS AND REPORTS REGULATION NUMBER 1, RECORD ROOM

\* \* \*

8. No records or excerpts from any record [shall be] . . . released from the record room except upon written order of the patient . . . or by due process of law. Records may be

<sup>26</sup> *Naddeo v. Degenshein*, 147 N.Y.S. 2d 586 (Sup. Ct., Kings County, 1955).

<sup>27</sup> See *Standards for Hospital Accreditation*, Joint Commission on Accreditation of Hospitals, 1957.

<sup>28</sup> HAYT, HAYT & GROESCHEL, *LAW OF HOSPITAL, PHYSICIAN, AND PATIENT*, p. 652 (1952); Letourneau, *Before You Disclose Information in Medical Records*, 80 Hosp. Man. 51 (July, 1955); *Ownership of and Access to Hospital Records*, 166 J.A.M.A. p. 796 (Feb. 15, 1958); Bulletin of the Joint Commission on Accreditation of Hospitals, (No. 10, 1955).

removed from the record room only upon order of the administrator by duly qualified persons for purposes of study or research. Patient records are the property of the institution and shall not be removed from the hospital premises except by court order.

The Division of Health has indicated that, in addition to the patient's consent for the release of information, it is desirable to obtain the approval of the attending physician or dentist. Note that the *Missouri* provision applies not only to the removal of the record, but also to the release of extracts from the record.

The *North Carolina* regulation applies to the removal of records specifically:

#### PART XIII MEDICAL RECORDS

##### Section C. Procedures

4. Records of patients are the property of the hospital and must not be taken from the hospital except under a subpoena. When taken from the hospital property under subpoena, they must be returned to the hospital at the end of the hearing for which they were directed to be procured. An administrative officer shall be responsible for the enforcement of this rule.

The *Pennsylvania* regulation is substantially the same as the provision above. The *South Carolina* regulation is to the effect that the records are the property of the institution and cannot be removed from the hospital except by court order. Some courts have held that a physician has a definable legal interest in the record.<sup>29</sup> While the attending physician has a clear medical interest in the record, it would seem he has no legal right to prevent disclosure by the hospital of information in the record.<sup>30</sup> In *Wohlgemuth v. Meyer*,<sup>31</sup> the court stated, in a malpractice action by the husband of the deceased against the hospital and practitioners;

The doctor-patient relationship is a fiduciary one and it is incumbent on the doctor to reveal all pertinent information to his patient. The same is true of the hospital-patient relationship.

<sup>29</sup> *Hampton Clinic v. District Court of Franklin County*, 231 Iowa 65, 300 N.W. 646 (1941), *McGarry v. J. A. Mercier Co.*, 272 Mich. 501, 262 N.W. 296 (1935). However, in *Application of Kabes*, 175 N.Y.S. 2d 83 (Sup. Ct., Chemung County 1958), the hospital sought to vacate a motion for examination of its record librarian on the ground, among others, that the records belong to the hospital and the doctors. The court in allowing the examination did not discuss this point.

<sup>30</sup> *Mussman v. Methodist Hospital of Indiana*, unreported case, no. C-20151, Superior Court, Marion County, Indiana, June 29, 1956; *Matter of Weiss*, 208 Misc. 1010, 147 N.Y.S. 2d 455 (1955).

<sup>31</sup> 139 Cal. App. 2d 326, 293 P. 2d 816 (1956). And see 166 J.A.M.A. at 800 (Feb. 15, 1958).

In the event of the death of the patient while under the care of the doctor and the hospital, the spouse has a right to know the cause of death. Withholding information would in a sense amount to misrepresentation.<sup>32</sup>

The medical record is a peculiar type of property; physically it belongs to the hospital. The institution may restrict the removal of the record from its premises, subject to supervening court order. The patient, however, has an interest in the contents of the record which cannot be denied, although the patient may have to protect his interest through recourse to the courts.<sup>33</sup>

## 2-2 RIGHT TO EXAMINE THE RECORD

Assuming that the hospital has ownership and the right to control the record, if the hospital allows the patient the right to see his record or if the patient gives his consent to the disclosure of information in the record, no real problems arise. However, the hospital can deny access to the record to the patient or his authorized agent or disclose information in the record to third parties without the patient's consent.

In a few instances, statutes have given the patient, his physician or authorized agent the right to examine and copy his medical record.<sup>34</sup> Other statutes specifically deal with the question of the subpoena and admissibility of hospital records.<sup>35</sup> [For a discussion of admissibility, see Section 3.] Some statutes deal specifically with the confidentiality of research information obtained from hospital records by or on behalf of state departments of health.<sup>36</sup> There are,

<sup>32</sup> *Id.* at 331, 293 P. 2d at 820.

<sup>33</sup> See *Matter of Weiss*, 208 Misc. 1010, 147 N.Y.S. 2d 455 (1955); *Wallace v. University Hospitals of Cleveland*, 164 N.E. 2d 917 (Common Pleas Ct., Cuyahoga County, Ohio, 1959).

<sup>34</sup> See CONN. GEN. STAT. ANN. §§ 4-104, 4-105 (1969); Each hospital receiving state aid must permit a patient or his physician or authorized attorney to examine the hospital record, including the history, bedside notes, charts, pictures and plates; and permit copies to be made. See also MASS. GEN. LAWS ANN. c. 111, § 70 (1971) and WIS. STAT. ANN. § 269.57 (Supp. 1972-73): Medical records of licensed hospitals may be inspected by anyone designated in a written authorization of the patient. *But see* also N.J. STAT. ANN. §§ 2A:82-41 to -45 (1952) permitting hospitals to allow examinations of patient's records by persons against whom a claim is asserted for compensation or damages for personal injuries. The provisions also apply to insurance carriers, attorneys and authorized agents, and states that hospitals shall not be liable for allowing such examinations.

<sup>35</sup> ALA. CODE ANN. tit. 7, §§ 383(1), 383(2) (Supp. 1971); MASS. GEN. LAWS ANN. c. 233, § 79 (Supp. 1973).

<sup>36</sup> CONN. GEN. STAT. ANN. § 19-6a (Supp. 1973); ILL. ANN. STAT. tit. 51, §§ 101 to 105 (Smith-Hurd 1966); MICH. STAT. ANN. §§ 325.131 to 325.134 (1967); NEB. REV. STAT. §§ 71-3401 to 71-3403 (Reissue Vol. 1966); S.D. CODE § 34-14-1 (1972).

in addition, several statutes which provide for the confidentiality of records of mental hospitals.<sup>37</sup>

The statutes dealing with the confidentiality of research are of particular interest. They provide that information, reports and other data procured in the course of medical study for the purpose of reducing morbidity or mortality, by health departments, state medical societies, allied medical societies or in-hospital staff committees of accredited hospitals, are to be strictly confidential and used only for medical research. The law goes on to provide that the information is not admissible as evidence in any action of any court or before any tribunal, board, agency or person. The furnishing of such information shall not subject any person, hospital, sanitarium, nursing or rest home or any agency to any action for damages or other relief. The law also provides that the disclosure of any information, records or other data obtained in any medical study, except that necessary for the purpose of the specific study, is unlawful and those who violate the provisions of the act are deemed to be guilty of a misdemeanor.

With reference to the mental health statutes, the *Alaska*, *South Carolina*, and *Kentucky* statutes relate to the records or reports in mental hospitals or in the department of mental health. The *Tennessee* statute applies to the medical records of patients in state hospitals and those patients receiving medical treatment in whole or in part at the expense of the state. It would appear that this *Tennessee* statute is broad enough to include any patient who receives medical care at the expense of a state agency. The *Colorado* statute provides that a licensed maternity home or hospital cannot divulge the contents of records relating to illegitimate children born therein or brought thereto except upon the order of the court or except as to information sent to the state or local departments of health. In *Alaska* and *South Carolina* there are penal provisions for violation of these laws.

There is also growing judicial authority on the point. In *Wallace v. University Hospitals of Cleveland*,<sup>38</sup> a former patient was granted a mandatory injunction ordering the hospital to allow the patient's counsel to examine her hospital record. The lower court required the hospital to allow the attorney to inspect any and all records in the hospital pertaining to the hospital stay and treatment of the patient and to furnish a complete photostatic copy of the record to the patient. However, the appellate court modified the order so as to allow the patient's attorney to inspect the records under the supervision of the

<sup>37</sup> ALASKA STAT. § 47.30.260 (1971); KY. REV. STAT. § 210.235 (1969); S.C. CODE ANN. § 32-1022 (Supp. 1971); TENN. CODE ANN. § 15-305 (Supp. 1971), § 33-1208 (Supp. 1972).

<sup>38</sup> 164 N.E. 2d 917 (Common Pleas Ct., Cuyahoga County, Ohio, 1959), affirmed and modified, 170 N.E. 2d 261 (Ohio Ct. App. 1960), motion to dismiss granted, 171 Ohio St. 487, 172 N.E. 2d 459 (1961).

hospital and to have photostatic copies made of such parts of the record as, in the discretion of the hospital, would be proper under the circumstances of the case, bearing in mind the beneficial interest of the patient and the general purpose for which the records were maintained. The patient appealed from this order, but between the perfection of the appeal and the argument before the Supreme Court of *Ohio*, the hospital sent a complete copy of the patient's records to the attorney and granted permission to the attorney to examine and inspect any records pertaining to the patient's stay. A motion to dismiss on the grounds that the case had become moot was therefore granted by the Supreme Court.

In *Pyramid Life Insurance Co. v. Masonic Hospital Ass'n. of Payne County*,<sup>39</sup> a Federal District Judge granted a mandatory injunction against the operators of a hospital restraining them from preventing inspection and copying of hospital records of the insurer's patient-policy holders by insurer's representatives who had authorizations signed by the patients. While the court acknowledged that the records were the property of the hospital, it declared that the keeper of the records does not have the right to possess and use the information constituting the records to the exclusion of the patient, his representatives, or those standing in his shoes.

The court went on to say that the keeper of hospital records is only the custodian and not the owner of the information constituting the patient's medical records, that the patient has a property right in the information appearing or portrayed in the records and that he, or those authorized by him, including an insurance company representative armed with authorizations signed by the patient, is entitled to make an inspection or to copy such records without resort to litigation. The court finally held that it was an interference with the plaintiff's business for the hospital or their agents to deny the insurance representatives the right to inspect and copy the patient's hospital and medical record and that such interference would be enjoined. One ground upon which the court appeared to base its decision was the fact that the hospital was required by statute and regulation to keep accurate and complete medical records of its patients. The court said records required to be kept by force of statute, regulation or judicial decision are at least quasi-public. As a consequence, inspection can be made by any person who has an interest such as would enable him to maintain or defend an action for which the document or record sought would furnish evidence or necessary information. The court then said that insurance companies have such a legitimate interest in determining whether claims under their policies are claims which they are obligated to pay.<sup>40</sup>

<sup>39</sup> 191 F. Supp. 51 (W.D. Okla. 1961).

<sup>40</sup> But see *Pyramid Life Insurance Co. v. Gleason Hospital*, 188 Kan. 95, 360 P. 2d 858 (1961).



In *Musmann v. Methodist Hospital*,<sup>41</sup> it was determined that a patient was entitled to see his record despite a hospital ruling requiring the attending physician's consent.

*Morris v. Hoerster*,<sup>42</sup> was a discovery proceeding against the superintendent of a state hospital and its chief of social service. The defendants objected on the grounds that this was in effect, a suit against the state. The court after holding that the rule of sovereign immunity did not apply, held that the plaintiff had a right to see his records as he had given his consent to disclosure of the information pursuant to a statute applicable to state mental hospitals. The case was remanded however, because the court said the release should be only as to information that is relevant and material for the purpose of a suit or for preparation of trial.

In *Matter of Weiss*,<sup>43</sup> a former patient brought a special proceeding to compel a hospital to submit to an examination and produce its records to enable the patient to ascertain the names of the doctors who had operated on him for the purpose of instituting a malpractice action. The court held that the hospital was not entitled to withhold the records from the patient for the purpose of concealing the identity of the physicians. The patient was held to have a right to see his own records.

There are a number of other decisions in *New York* involving pre-trial discovery and examination proceedings which indicate judicial recognition of the patient's right to view his record.<sup>44</sup> However, these cases must be taken in their context. Pre-trial discovery and examination are procedural remedies and do not create an absolute right in the patient to see his record at anytime. Such a right to pre-trial discovery and examination will be defined by the applicable statute or rule and will not be recognized in the absence of pending or threatened litigation.

Where there is no clear authority spelling out a patient's right, generally, to examine his record, the decision to allow or not allow the patient or his authorized agent to see the record can be made on the basis of administrative considerations, taking into account the circumstances of the particular case. Ordinarily, no adverse legal consequences will arise if the hospital refuses to allow a patient to see his record, absent non-compliance with a court order. The possi-

<sup>41</sup> Unreported case, No. C-2051, Superior Court, Marion County, Indiana, June 29, 1956. See cases cited in note 29, *supra*.

<sup>42</sup> 348 S.W. 2d 642 (Tex. Civ. App., 1961).

<sup>43</sup> *Supra* note 33.

<sup>44</sup> *Glazer v. Department of Hospitals of the City of New York*, 2 Misc. 2d 207, 155 N.Y.S. 2d 414 (1956); *Romano v. Mt. Sinai Hospital*, 150 N.Y.S. 2d 246 (Sup. Ct. Queens County 1956). *But cf. In re Hufstutler*, 220 App. Div. 587, 222 N.Y. Supp. 43 (1927); *Jaffe v. City of New York*, 196 Misc. 710, 94 N.Y.S. 2d 60 (1949); *Petition of Cenci*, 185 Misc. 479, 57 N.Y.S. 2d 231 (1945).

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bility of a suit for damages based on a refusal by the hospital to allow the patient to see his records seems remote.

### ¶ 2-3 DISCLOSURE WITHOUT THE PATIENT'S CONSENT

A crucial question presents itself in situations where the patient cannot or will not consent to the release or disclosure of his records. In some instances statutes provide for examination of hospital records by those persons against whom liability is asserted under hospital lien laws. [See For a discussion of these statutes, see FINANCIAL MANAGEMENT II, ¶ 1-7.] Of course, when a court order directs that the records be opened, consent is not required.<sup>45</sup> If the hospital is sued by the patient, the hospital may use the hospital records in its own defense. Also, the hospital may allow physicians to consult its medical records for the purpose of study and may employ the information in the record, or the records themselves, for the purposes of statistical evaluation, research and education.

If the information is disclosed without the patient's consent, does a right of action arise for which the hospital must respond in damages? There is an assumption that the physician-patient privilege affects any use of the so-called confidential matter in a medical record. This assumption is incorrect. The rule prohibiting the disclosure of privileged medical communications is statutory and applies only with respect to disclosures in judicial or quasi-judicial proceedings.<sup>46</sup> The out-of-court disclosure of information, while perhaps unethical, does not give rise to a cause of action under the privileged communications statutes.<sup>47</sup>

*Massachusetts* and *Wyoming*, by regulation, provide that confidential information obtained from medical records shall be furnished only on the written

<sup>45</sup> See *Application of Kabes*, 175 N.Y.S. 2d 83 (Sup. Ct., Chemung County 1958), wherein the court indicated that the patient's application for an order for examination constituted authorization for such examination. *But cf. Tripp v. Knox*, 165 N.Y.S. 2d 660 (Sup. Ct., Albany County 1956), wherein the court directed the plaintiff-patient to make the records available to the court. The reasoning being that since plaintiff would almost inevitably have to waive her personal privilege to prove her case, the records should be made accessible.

<sup>46</sup> *Noble v. United Benefit Life Ins. Co.*, 230 Iowa 471, 297 N.W. 881 (1941); *Jacobs v. City of Cedar Rapids*, 181 Iowa 407, 164 N.W. 891 (1917); *Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920); *Buffalo Loan Trust & Safe Deposit Co. v. Knights Temple & Masonic Mutual Aid Ass'n.*, 126 N.Y. 450, 27 N.E. 942 (1891); *Boyle v. Northwestern Mutual Relief Ass'n.*, 95 Wis. 312, 70 N.W. 351 (1897). See *Chafec, Privileged Communications*, 52 YALE L.J. 607, 616, 617 (1943).

<sup>47</sup> See cases cited note 45, *supra*; but see language of the court in *Collins v. Howard*, 156 F. Supp. 322 (D.C. Ga. 1957); *Alexander v. Knight*, 177 A. 2d 142 (Pa. Super. 1962).

authority of the patient or the executor of his estate.<sup>48</sup> The *Massachusetts* regulation also gives the attending physician the authority to allow such disclosure.

*Connecticut, Illinois, Michigan, Nebraska and South Dakota* permit the use of confidential information in medical research conducted under the auspices of the health department.<sup>49</sup>

Two possible avenues appear to be available to patients who can show injury as a result of a disclosure of information in their medical records by hospitals or physicians. The patient may possibly sue on a theory that he was defamed or that the disclosure was an invasion of his right to privacy.

#### ¶ 2-4 Defamation

Defamation may be defined as written or oral communication, to someone other than the person defamed, of matters concerning a living person which tend to injure reputation.<sup>50</sup> Under traditional concepts, libel was a written form of defamation while slander was oral, and libel was actionable without proof of actual damage. Certain types of slander, such as the imputation of crime or a loathsome disease, fell under the same rule, although ordinarily, special damages would have to be shown in order for oral publications to be actionable. Medical records may contain information which, if published, would tend to affect a person's reputation in the community adversely. Thus, conceivably, disclosure by the hospital to an unauthorized person could result in an action for defamation.

However, the possibility of a patient obtaining a recovery against the hospital is slight. In *Gilson v. Knickerbocker Hospital*,<sup>51</sup> plaintiff sued the hospital for libel, claiming that by complying with a lawful subpoena, the hospital had maliciously allowed the publication of false and defamatory matter contained in the medical record to be published. The record contained the observation that plaintiff was under the influence of alcohol. The court granted the hospital's motion for summary judgment, stating that the defendant's act was absolutely privileged in that it was acting pursuant to lawful judicial process.

It is clear that when truthful information is disclosed with good intention and for justifiable ends, no action will lie.<sup>52</sup> Release of information to interested parties would be protected by the above rule. With reference to false informa-

<sup>48</sup> MASSACHUSETTS: LICENSURE RULES AND REGULATIONS FOR HOSPITALS, 1950 (Dep't. of Public Health) ch. 2, II, B5; WYOMING: STANDARDS, RULES AND REGULATIONS FOR HOSPITALS AND RELATED FACILITIES, 1969 (Dep't of Public Health) ch. I, § 14, a, 2.

<sup>49</sup> See note 36, *supra*.

<sup>50</sup> PROSSER, TORTS § 111, pp. 737-751 (4th ed. 1971).

<sup>51</sup> 280 App. Div. 690, 116 N.Y.S. 2d 745 (1952).

<sup>52</sup> PROSSER, *op. cit. supra* note 50, § 116, p. 797. RESTATEMENT, TORTS § 582 (1938).

tion which may be in the record, such as an incorrect diagnosis, it should be noted that only those publications which tend to diminish the esteem, respect, good will and confidence of the plaintiff in the community, or those publications which tend to excite adverse, derogatory or unpleasant feelings or opinions about the plaintiff are actionable.<sup>53</sup> It seems unlikely that disclosures of inaccurate information concerning a man's medical status or treatment will be considered defamatory.

Moreover, there is in the law of defamation a conditional or qualified privilege which exists as to:

... communications made in good faith, without actual malice, with reasonable or probable grounds for believing them to be true, on a subject matter in which the author of the communication has an interest, or in respect to which he has a duty, public, personal, or private, either legal, judicial, political, moral, or social, made to a person having a corresponding interest or duty.<sup>54</sup>

In those instances where a hospital is serving its own interests, as in its efforts to procure payment from a third party, there can be no doubt that communications made in such circumstances are privileged since the hospital may be termed an interested party. Also, in those instances where a public interest is being served, such as to protect the community, or a part thereof, from highly contagious diseases, it would seem proper to inform those persons interested in the relevant facts.<sup>55</sup>

Questions have arisen relating to the disclosure of statements or reports of conferences or proceedings among the trustees, officers, medical staff personnel and committees with reference to the qualifications of physicians who come up for annual reappointment to the medical staff or whose work is subject to review and assessment. Such statements or reports together with comments or

<sup>53</sup> *Id.* § 111, p. 739.

<sup>54</sup> 53 C.J.S. *Libel & Slander* § 89, p. 143 (1948).

<sup>55</sup> In *Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920), the Nebraska Supreme Court, in ruling upon the question of whether a doctor had violated a statute which prohibited out-of-court disclosure of confidential communications, held the doctor not liable for disclosing to a hotel the fact that his patient had a venereal disease. Without disclosing whether the diagnosis was correct, although it was intimated that it was not, the court reasoned that the rules of qualified privilege, as they appear in the law of defamation would govern this case. The doctor was held to have had a moral or legal duty to disclose to those persons who might be affected by this contagious disease the fact that he believed the patient to be so afflicted. The court, despite the fact that it was referring to an action for violation of a professional confidence, used exactly the same standard as is used in measuring a qualified privilege in an action for defamation. See *Shoemaker v. Friedburg*, 80 Cal. App. 2d 911, 183 P. 2d 318 (1947); *Patton v. Jacobs*, 118 Ind. App. 358, 78 N.E. 2d 789 (1948).

communications made by persons with an interest are qualifiedly privileged at least to the extent that an unfavorable comment will not give rise to an action of defamation. [For a statute protecting medical staff committees from liability in the performance of their functions, see *MEDICAL STAFF, State-by-State Analysis, California.*]

In *Raymond v. Cregar*<sup>56</sup> the court, in an action brought by a physician who had failed of reappointment and who complained that statements were made about him in malice, said:

Persons who serve on the governing boards of institutions which boards have the obligation to pass upon the qualifications of the personnel, should have the widest latitude in discussing the qualifications of candidates for staff appointments, so long as they act in good faith. Statements made in such discussions are qualifiedly privileged. But the qualified privilege is lost if the statements are made with "malice." Malice in this sense may be described as an improper purpose, i.e., a purpose other than furthering the public interest which is legally protected by qualified privilege. . . . The fundamental test is the *bona fides* of the communication.<sup>57</sup>

In this case the court found that the plaintiff's allegation of malice against a trustee was sufficient to bring the matter to trial.

A more difficult question is presented when neither the interest of the hospital nor the general public is directly involved. Such cases may arise when there are requests by insurance companies, litigating parties, newspapers, etc., for permission to examine or obtain information from the hospital records. It is conceivable that in answering a private and confidential inquiry, the hospital is acting in the discharge of a legal, moral or social duty, and its answer may thus be privileged. This assumption has its basis in those cases which have held that when an apparently interested party makes a request for information concerning the general business character or credit of an individual, there is created a moral justification for disclosure because, under ordinary social standards, a reasonable man would feel called upon to speak.<sup>58</sup> By analogy, it can be

<sup>56</sup> 38 N.J. 472, 185 A. 2d 856 (1962), *affirming in part and reversing in part*, 72 N.J. Super. 73, 178 A. 2d 29 (1962).

<sup>57</sup> 38 N.J. 472, —, 185 A. 2d 856, 861 (1962).

<sup>58</sup> *Richardson v. Gunby*, 88 Kan. 47, 127 P. 533 (1912); *Melcher v. Beeler*, 48 Colo. 233, 110 P. 181 (1916); *Froslee v. Lund's State Bank*, 131 Minn. 435, 155 N.W. 619 (1915); *Posnett v. Marble*, 62 Vt. 481, 20 A. 813 (1890).



theorized that disclosure of data in medical records to an insurance company or to a litigating party may be qualifiedly privileged, since the interest of the community in securing justice would create a moral duty in the hospital to comply with such a request. Illustrative of this point is the holding that an insurance company made a qualifiedly privileged publication concerning a person's health when it caused certain information, adverse to the plaintiff's interest, to be recorded with an agency subscribed to by other life insurance companies.<sup>59</sup> Other cases illustrate a similar principle.<sup>60</sup> The extent of the qualified privilege is uncertain and impossible to reduce to a formula. The publication must be justified by the importance of the interest served, and it must be called for by a legal or moral "duty," or by generally accepted standards of decent conduct.

A request for information by a totally uninterested party can never create a situation which is qualifiedly privileged. In order that a disclosure be privileged, the party to whom it is made must always have an interest. Whether or not the information was requested or volunteered will go toward determining whether the publisher acted in good faith or had a moral duty to communicate. A party is not precluded from volunteering information to an interested party when the communicant is serving his self-interest or a community interest, or when there is an apparent legal or moral duty to speak, such as in a situation where a patient is attempting to defraud his insurance company or a party he is suing. However, where none of these conditions is present, it would seem advisable to await a request by an interested party in order that there be created a moral duty to speak.

It can be concluded that disclosure of information or permitted examination of hospital records generally will not lead to liability for defamation.

## ¶ 2-5 Invasion of Privacy

Several jurisdictions recognize the principle that an individual has the right to be protected from the mass dissemination of information pertaining to his

<sup>59</sup> *Mayer v. Northern Life Ins. Co.*, 119 F. Supp. 536 (N.D. Cal. 1953).

<sup>60</sup> *Rude v. Nass*, 79 Wis. 321, 48 N.W. 555 (1891), a qualified privilege existed where the defendant answered a letter about a nun written in the interests of a father whose daughter had been associating with the nun, despite lack of apparent concern in the matter by the defendant; *Doane v. Grew*, 220 Mass. 171, 107 N.E. 620 (1915), a qualified privilege attached to the response by an employer concerning a former servant with the respect to an inquiry made by a prospective employer of the servant.

personal, private affairs, and from the unconsented to commercial use of his name, likeness or other personal matter.<sup>61</sup> This right has been called the right of privacy.<sup>62</sup> An invasion of this right is an unwarranted appropriation or exploitation of one's personality; the publicizing of one's private affairs with which the public has no legitimate concern, or a wrongful intrusion into one's private activities. To be actionable this invasion, exploitation, or intrusion must be done in such a manner as to cause outrage or mental suffering, shame or humiliation to a person of ordinary sensibilities.

Hospitals could be held liable under this principle if they were responsible for the unwarranted intrusion into the private affairs of a patient. In *Bazemore v. Savannah Hospital*,<sup>63</sup> a petition was brought by parents against the hospital, a photographer and newspaper for damages, and to enjoin the unauthorized publication of pictures of their deceased, malformed child. On appeal from a judgment sustaining a general demurrer, the Supreme Court of Georgia held that the petition stated a cause of action.<sup>64</sup> The petition specifically alleged a duty on the part of the hospital:

... upon the arrival of said child, to properly care for and administer to it such skill, comforts, and protection as would safely protect it ... [from] an invasion of an unauthorized person or persons, whereby its monstrosity and nude condition would likely be exposed to any person or persons, and particularly to the general public; ...<sup>65</sup>

<sup>61</sup> See Annots., 138 A.L.R. 22 (1942); 14 A.L.R. 2d 750 (1950). Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, West Virginia and the District of Columbia have expressly or impliedly recognized the existence of a common law action for invasion of privacy. Nebraska, Rhode Island, Texas, Wisconsin, and probably Washington have determined that there is no common law action for invasion of privacy. There are statutory provisions, limited in scope, in New York, Oklahoma, Utah and Virginia. In Massachusetts the courts have not ruled on the substantive question of whether a common law action existed, since under the factual situations of the cases entertained, even if that right did exist, the facts before the courts did not constitute an invasion of privacy.

<sup>62</sup> The principle was first enunciated by Warren and Brandeis in *The Right to Privacy*, 4 HARV. L. REV. 193 (1890). See Nizer *The Right of Privacy*, 39 MICH. L. REV. 526 (1941).

<sup>63</sup> 171 Ga. 257, 155 S.E. 194 (1930).

<sup>64</sup> The case was reversed and apparently remanded for a ruling by the trial court on the special demurrers which had been entered by the defendants. On the question of the liability of the hospital, the court makes no ruling but cites *Morton v. Savannah Hospital*, 148 Ga. 438, 96 S.E. 887 (1918), which allows liability to the extent of non-trust fund assets.

<sup>65</sup> *Bazemore v. Savannah Hospital*, 171 Ga. 257, 155 S.E. 194, 195 (1930).



While the *Bazemore* case dealt with the practice of photographing patients, it is possible that the release or disclosure of information in a medical record could lead to liability under this theory. However, the right of privacy is not an absolute right. The distinguishing characteristic of the right is that it is to protect the private citizen from mass dissemination of information concerning his private, personal affairs.<sup>66</sup> It has also been said that oral publication cannot constitute an invasion of privacy,<sup>67</sup> nor can the publication of data to an extent reasonably calculated to serve the legitimate interests of the publisher constitute such an invasion.<sup>68</sup> Thus, the release or disclosure of information in the medical record to private individuals, such as attorneys, insurance company representatives or family members, would not ordinarily constitute an invasion of the right of privacy. It must further be remembered that the release, disclosure or publication must be of such a nature as to outrage or cause mental suffering, shame or humiliation to a person of ordinary sensibilities.<sup>69</sup>

However, some courts have expanded the doctrine to cover the cases of wrongful physical intrusion into the private life of a person although no mass dissemination was involved. In *Clayman v. Bernstein*,<sup>70</sup> an action was brought by a wife and husband for an injunction to restrain the defendant doctor from developing or making prints of certain films and negatives of pictures taken of plaintiff wife's facial disfigurement while she was in the hospital in a semi-conscious state. Neither the wife, husband or any of the family consented to the taking of such pictures. The court held that the wife's right of privacy was invaded by the taking of the photographs; there was no need for publication and the injunction was issued. [See For a copy of a consent form for the taking of photographs, see CONSENTS, ¶ 3-11.]

<sup>66</sup> See PROSSER, TORTS § 117, p. 810 (4th ed. 1971).

<sup>67</sup> *Pangallo v. Murphy*, 243 S.W. 2d 496 (Ky. Ct. App. 1951); *Brents v. Morgan*, 221 Ky. 765, 299 S.W. 967 (1927); *Melvin v. Reid*, 112 Cal. App. 285, 297 P. 91 (1931); *Warren and Brandeis, The Right to Privacy*, 4 HARV. L. REV. 193 (1890).

<sup>68</sup> *Patton v. Jacobs*, 118 Ind. App. 358, 78 N.E. 2d 789 (1948); *Voney v. Turner*, 240 S.W. 2d 588 (Ky. Ct. App. 1951); *Louis v. Physicians & Dentists Credit Bureau*, 27 Wash. 2d 267, 177 P. 2d 896 (1947). See *Brents v. Morgan*, 221 Ky. 765, 299 S.W. 967 (1927) and *Trammell v. Citizens News Co.*, 285 Ky. 529, 148 S.W. 2d 708 (1941), where the manner of publication was not on a scale easily calculated to serve legitimate interests of the publishers.

<sup>69</sup> See *Annotts.* 138 A.L.R. 22 (1938), 14 A.L.R. 2d 750 (1950) and *Nizer op. cit.*, *supra* note 41. See also, 62 AM. JUR. *Privacy* § 1, p. 677 (1972); *Reid v. Real Detective Pub. Co.*, 63 Ariz. 294, 162 P. 2d 133 (1945); *Cason v. Baskin*, 159 Fla. 31, 30 So. 2d 635 (1947); *Davis v. General Finance & Thrift Corp.*, 80 Ga. App. 708, 57 S.E. 2d 225 (1950); *Warren and Brandeis, The Right to Privacy*, 4 HARV. L. REV. 193, 216 (1890).

<sup>70</sup> 38 Pa. D. & C. 543 (Phila. County 1940). See *Welsh v. Pritchard*, 125 Mont. 517, 241 P. 2d 816 (1952); *Housh v. Peth*, 165 Ohio St. 35, 133 N.E. 2d 340 (1956); *Rhodes v. Graham*, 238 Ky. 225, 37 S.W. 2d 46 (1931).

The right to privacy issue has been raised more frequently in recent years in conjunction with the liberalization of pre-trial discovery rules prompting litigating parties to request discovery of information from hospital patients' medical records. In determining whether to grant such requests, the courts appear to be using a balancing test, weighing patients' rights to privacy against the right to discover information for the purpose of preparing for litigation. In at least two recently decided cases, courts have determined to protect the right to privacy. Both cases involve requests for information relating to the performance by physicians of therapeutic abortions to be used as evidence against the physicians and their hospitals.

In *Williams v. Thomas Jefferson University*,<sup>71</sup> a malpractice action, the plaintiff patient asked the court to require the defendant hospital to furnish her with the names and addresses of former patients of the defendant physician and information regarding their treatment in connection with the performance of therapeutic abortions. Plaintiff wanted this information to enable her to direct inquiries to these other patients in order to gather evidence to impeach the credibility of the physician. The court denied the request on the grounds that plaintiff's reasons for demanding the information were far outweighed by the interests of the other abortion patients against the exposure of private and personal data contained in their hospital records.

The patient's right to privacy has even been protected against a search of hospital records for evidence relevant to a criminal prosecution of three physicians on the charge of conspiracy to commit illegal abortions at a designated hospital on a specific date. A subpoena had been issued, at the request of the District Attorney, directing the hospital involved to produce the medical records of all patients who had undergone therapeutic abortions at the hospital during the preceding year and other pertinent information given by these patients to the hospital and their physicians. Three former patients of the hospital who had obtained therapeutic abortions, thereupon instituted a class action on behalf of themselves and all other women whose medical records were to be produced, seeking an injunction prohibiting the hospital from disclosing any personal information about them pursuant to the District Attorney's subpoena.<sup>72</sup> In support of their claimed right to object to the production of their records, plaintiffs relied upon the physician-patient privilege established by statute:

**§ 328. PHYSICIANS AND SURGEONS NOT TO DISCLOSE  
INFORMATION; EXCEPTION.**

**No person authorized to practice physics or surgery shall  
be allowed, in any civil case, to disclose any information**

<sup>71</sup> *Supra* note 17.

<sup>72</sup> *Berman et al. v. Duggan et al.*, 119 PITT. LEGAL J. 226 (C.P. Allegheny County, Civil Division 1971).

which he acquired in attending the patient in a professional capacity, and which was necessary to enable him to act in that capacity, which shall tend to blacken the character of the patient, without consent of said patient, except in civil cases, brought by such patient, for damages on account of personal injuries.<sup>73</sup>

The District Attorney argued that the statute, by its own terms, applies to civil cases, but does not extend the privilege to criminal proceedings. However, the court held that the hospital records constituted privileged communications, and the subpoena issued for their production was declared void and vacated. In reaching this result, the court said:

Although the hospital records might be of some aid in the investigation of the criminal charges filed against the three physicians, this court recognizes a paramount public interest in maintaining the confidential relationship between physician and patient. The detrimental effect upon a physician's ability to tend to his patient in a responsible professional capacity is much too great a price to pay for any possible benefit to be derived from sifting through voluminous records of personal data in search of evidence.<sup>74</sup>

It remains to be seen whether the privileged communication theory will be extended beyond abortion situations to insulate the rights of patients who are not actual parties to the court proceedings against discovery procedures invoked by litigants. In any event, a hospital that receives a request for discovery of information from its records or a court order directing it to produce such information should seek competent legal advice immediately. Absent such advice, the hospital may believe it has a duty to comply with the request and, upon compliance, may find itself liable to the patients whose records were produced for invasion of privacy. However, if the hospital refuses to comply with a valid court order it will be acting in contempt and thereby subjecting itself to the penalty attached to such disobedience. In order to avoid this dilemma, hospital counsel may petition the court to stay its order for the production of records until it can be determined whether compliance on the hospital's part will result in liability for invasion of a patient's right to privacy.

The right of privacy, generally, is the right of a private person to be kept out of the public spotlight. Thus, without more, it can be said that a disclosure of information from the medical record to private individuals could not be an invasion of a patient's right. In addition, this kind of publication may be privileged;<sup>75</sup> either absolutely, as in the case of statements made in court before legislative and other official public bodies, or qualifiedly, as in the case

<sup>73</sup> PA. STAT. ANN. tit. 28, § 328 (1958).

<sup>74</sup> *Supra* note 72 at 236.

<sup>75</sup> See Warren and Brandeis *op. cit.*, *supra* note 69, at 216.

of a discharge of some public or private duty, legal or moral. [§ 2-4] For a discussion of communications which may be privileged, see ¶ 2-4.]

¶ 2-6 NEWS RELEASES: Perhaps the hospital practice most likely to give rise to questions of the invasion of privacy is the release of information concerning patients to news agencies. While the right of privacy does not prohibit publications which are of public or general interest,<sup>76</sup> the extent of publication is still a matter to be weighed carefully by the hospital in each case. Announcements of the admission or discharge of patients ordinarily pose no problem. However, the situation may be different where the hospital caters to specific diseases which are considered shameful in the popular mind. To publicize the fact that Mrs. Jones gave birth to a normal, healthy baby boy could not ordinarily be considered an overstepping of the bounds of propriety; but to publicize the fact that Mrs. Jones gave birth to a still-born monstrosity, or that Miss Brown had a child might be actionable.

The patient may be a public figure; his prominence, in itself, makes virtually all of his doings of interest to the public.<sup>77</sup> Relatively obscure people may voluntarily take certain actions which will bring them before the public, or may be victims of occurrences which are newsworthy, such as accidents, deliberate injuries, attempted suicides, police cases, etc., thus making the particular persons of interest to the public. The latitude extended to the publication of personal matters, names, photographs and the like varies as to these individuals. The public figure may not complain if his life is given some publicity, and this may be true long after he has ceased to be in the public eye.<sup>78</sup> The ordinary citizen who voluntarily adopts a course of action which is newsworthy, cannot be heard to complain if the activity is reported along with his name and picture.<sup>79</sup> However, as time passes the identity of the participant loses importance and an action for invasion of the right of privacy may then exist.<sup>80</sup>

<sup>76</sup> *Id.*

<sup>77</sup> *Cason v. Baskin*, 159 Fla. 31, 30 So. 2d 635 (1947).

<sup>78</sup> *Martin v. Dorton*, 210 Miss. 668, 50 So. 2d 391 (1951); *Sidis v. F-R Pub. Corp.*, 113 F. 2d 806 (2d Cir. 1940); *Cohen v. Marx*, 94 Cal. App. 2d 704, 211 P. 2d 320 (1950); *Flake v. Greensboro News Co.*, 212 N.C. 780, 195 S.E. 55 (1938); *Elmherst v. Pearson*, 153 F. 2d 467 (D.C. Cir. 1945). See *Cason v. Baskin*, 159 Fla. 31, 30 So. 2d 635 (1947).

<sup>79</sup> *Berg v. Minneapolis Star & Tribune Co.*, 79 F. Supp. 57 (D.C. Minn. 1948), decided without determining whether or not the common law right of privacy exists in Minnesota; *Langford v. Vanderbilt University*, 199 Tenn. 389, 287 S.W. 2d 32 (1956); *Burnstein v. Nat'l. Broadcasting Co.*, 129 F. Supp. 817 (D.C., D.C. 1955); *Smith v. Doss*, 251 Ala. 250, 37 So. 2d 118 (1948); *Metter v. Los Angeles Examiner*, 35 Cal. App. 2d 304, 95 P. 2d 491 (1939).

<sup>80</sup> *Burnstein v. Nat'l. Broadcasting Co.*, 129 F. Supp. 817 (D.C., D.C. 1955); *Mau v. Reo Grand Oil*, 28 F. Supp. 845 (N.D. Cal. 1939); *Melvin v. Reid*, 112 Cal. App. 285, 297 P. 91 (1931). But cf. *Smith v. Doss*, 251 Ala. 250, 37 So. 2d 118 (1948).



It has been held that the name and photograph of the victim of a circumstance which is itself newsworthy may be published.<sup>81</sup> However, in *Barber v. Time, Inc.*,<sup>82</sup> the publication of a story, with the name and picture of the plaintiff, concerning a strange ailment for which she was being treated, was actionable. In making its determination the court said:

Certainly if there is any right of privacy at all, it should include the right to obtain medical treatment at home or in a hospital for an individual personal condition (at least if it is not contagious or dangerous to others) without personal publication. . . . Whatever the limits of the right of privacy may be, it seems clear that it must include the right to have information given to or gained by a physician in the treatment of an individual's personal ailment kept from publication which would state his name in connection therewith without such person's consent.<sup>83</sup>

While it may be argued that the reasoning of the *Missouri* court in the *Barber* case is applicable only to illnesses, as distinguished from accidents or catastrophes, the illness was at least as newsworthy as any physical harm which may have occurred in an accident. The *Barber* case appears to conflict with the majority view,<sup>84</sup> however, the case may be distinguished because publication in the national magazine was in a section devoted to medical news. Public interest was not keyed to the identity of the victim, but rather to the disease or illness, consequently the use of the victim's name and picture was not necessary and, because the illness was so degrading in nature, she was allowed to recover. However, in the case of newsworthy occurrences reported in the daily newspapers, motion pictures, radio or television, the identity of the participants or victims is as much a part of the news as the facts concerning their misfortune.

In the ordinary situation hospitals may release information of legitimate news value for immediate publication by news agencies without fear of a suit for invasion of the right of privacy. Nevertheless, hospital policy concerning the release of information to newspapers and other mass media should be formulated so that the interests of the patient are always protected.

<sup>81</sup> *Bremmer v. Journal-Tribune Pub. Co.*, 247 Iowa 817, 76 N.W. 2d 762 (1956); *Jones v. Herald Post Co.*, 230 Ky. 227, 18 S.W. 2d 972 (1929); *Themo v. New England Newspaper Pub. Co.*, 306 Mass. 54, 27 N.E. 2d 753 (1940); *Kelly v. Post Pub. Co.*, 327 Mass. 275, 98 N.E. 2d 286 (1951).

<sup>82</sup> 348 Mo. 1199, 159 S.W. 2d 291 (1942).

<sup>83</sup> *Id.* at 1207, 159 S.W. 2d at 295.

<sup>84</sup> See cases cited in note 80, *supra*; and RESTATEMENT, TORTS § 867 (1939).

### ¶ 2-7 Betrayal of Professional Secrets

One final theory which might give rise to liability for the disclosure of the information in the medical record without consent need only be mentioned in passing, because it mainly affects the activities of the physician, and is only tangentially applicable to hospitals. It is possible that release or disclosure of the medical record<sup>85</sup> might give rise to liability because it results in the betrayal of professional secrets to the detriment of the patient.

In *Simonsen v. Swensen*,<sup>85</sup> the plaintiff's physician informed the plaintiff's landlady that the plaintiff was suffering from a contagious venereal disease. The landlady immediately forced the plaintiff to vacate the premises. Plaintiff sued the physician on the theory that a confidential communication had been revealed. The court held that the statute pertaining to confidential communications applied only to courtroom testimony, but pointed out that the statute relating to unprofessional conduct of physicians might have been applicable. This statute specifically enumerated the betrayal of professional secrets to the detriment of the patient as a cause for revocation of a doctor's license. The court, however, found that while, theoretically, civil liability might result, the act of the physician in this case was qualifiedly privileged, since the doctor had a "duty" to disclose the existence of the contagious disease to persons who might be affected. His disclosure to the landlady was thus privileged and he was not held liable to the patient.<sup>86</sup> In theory, if a licensing statute or regulation affecting hospitals were to prohibit the disclosure of confidential information concerning patients, the hospital could be liable civilly. The chance of liability under this theory is quite remote, however.

## SECTION 3

### ADMISSIBILITY OF MEDICAL RECORDS IN EVIDENCE

The increasing incidence of personal injury litigation, and the expanding use of life, accident and health insurance are major factors which operate to make medical records important evidentiary material. However, there is some diversity of opinion as to the admissibility of these documents in judicial and quasi-judicial proceedings.<sup>87</sup> The medical record is hearsay in that it is a statement made extra-judicially, introduced into a court proceeding for the purpose of proving the facts therein.<sup>88</sup> Again, the medical record may be deemed to be

<sup>85</sup> 104 Neb. 224, 177 N.W. 831 (1920).

<sup>86</sup> See notes, 20 COLUM. L. REV. 890 (1920); 30 YALE L. J. 289 (1921); 34 HARV. L. REV. 312 (1921).

<sup>87</sup> See generally, Annots. 75 A.L.R. 378 (1931); 120 A.L.R. 1124 (1939); 175 A.L.R. 274, 286 (1948); 38 A.L.R. 2d 778 (1954); 44 A.L.R. 2d 552 (1955). See also 6 WIGMORE, EVIDENCE § 1707 (3rd ed. 1940).

<sup>88</sup> See MCCORMICK, EVIDENCE § 313, p. 731 (2d ed. 1972).



a confidential communication between the patient and the physician and protected from disclosure on that account.

These records are, nevertheless, admitted into evidence on a variety of grounds.<sup>89</sup> In jurisdictions whereby statute, records are required to be kept by certain hospitals, such documents, including medical records, may be admitted under the exception to the hearsay rule relating to public or official records,<sup>90</sup> and are admissible under workmen's compensation and lien laws. In other states, medical records are admissible where it can be shown that they are made in the regular course of business.<sup>91</sup> The Uniform Business Records as Evidence Act, has been adopted by a large number of states, while several have adopted a Model Act which also provides for the admissibility of records made in the regular course of business. These laws are generally applicable. In those states which have adopted neither the Uniform nor the Model Act, medical records may, nevertheless, be admissible. [REDACTED] For a listing of the relevant statute in each state, see *Appendix B.* Of course, these records must meet the usual evidentiary tests of relevancy and materiality, as well as competency.<sup>92</sup>

However, having met these tests, the introduction of medical records may still be objected to on the ground that the matter contained therein is information subject to the operation of the physician-patient confidential communication statute. Although these statutes have been held to apply to confidential matters appearing in medical records, they will affect the hospital directly only in those cases in which the hospital is a litigant. In suits between the patient and others it is not the hospital's concern or right to assert the privilege, or

<sup>89</sup> *Id.* See also *State v. Stracuzzi*, 79 Ariz. 314, 289 P.2d 187 (1955); *Pierce v. Paterson*, 50 Cal. App. 2d 486, 123 P. 2d 544 (1942); *Pressley v. State*, 207 Ga. 274, 61 S.E. 2d 113 (1950); *Bell v. Bankers Life & Casualty Co.*, 327 Ill. App. 321, 64 N.E. 2d 204 (1945); *Motley v. State*, 174 Miss. 568, 165 So. 296 (1936); *Kirkpatrick v. Wells*, 319 Mo. 1040, 6 S.W. 2d 591 (1928); *Dallas Coffee & Tea Co. v. Williams*, 45 S.W. 2d 724 (Tex. Civ. App. 1931); *Garza v. San Antonio Transit Co.*, 180 S.W. 7d 1006 (Tex. Civ. App. 1944); *Hempton v. State*, 111 Wisc. 127, 86 N.W. 596 (1901).

<sup>90</sup> See LA. REV. STAT. ANN. § 13:3714 (1968), providing for admissibility of certified copies of records of certain hospitals.

<sup>91</sup> See MCCORMICK, *op. cit. supra* note 88; 6 WIGMORE, EVIDENCE § 1707 (3d ed. 1940). Some states still have no legislation pertaining to the admissibility of shopbooks or regular business entries.

<sup>92</sup> See *Munsie v. Highland Hospital of Rochester*, 8 Misc. 2d 487, 168 N.Y.S. 2d 178 (1957), hospital rules and regulations not subject to inspection or examination before trial when rules not admissible in evidence under pleadings; *Case v. Vearrindy*, 339 Mich. 579, 64 N.W. 2d 670 (1954), statements by patient placed in record excluded. See also *Flemming v. Thorson*, 231 Minn. 343, 43 N.W. 2d 225 (1950); *Greene v. City of Cleveland*, 150 Ohio St. 441, 83 N.E. 2d 63 (1948).

attempt to destroy it when the records are subpoenaed.<sup>93</sup> This problem is for the courts and parties litigant. In those cases involving hospitals, the privilege will be effective only as to certain matter in certain types of causes, if waiver cannot be shown.<sup>94</sup>

The hearsay and confidential communications rules, as they apply to medical records, do not affect the use of hospital records in non-judicial situations; thus, while these considerations are of note, other factors come into play in determining what matters may be disclosed out-of-court without legal repercussions. [REDACTED] For a discussion of this topic, see Section 2.]

### APPENDIX A CONFIDENTIAL COMMUNICATIONS STATUTES

The following are statutes which protect the communications made between a patient and his physician from disclosure in judicial or quasi-judicial proceedings under certain circumstances. The statutes vary as to the scope and extent of the patient's privilege to prevent disclosure by the physician as well as to the nature of the proceeding in which it may be raised.

**Alaska:** Alaska Stat. § 18.20.090 (1969).

**Arizona:** Ariz. Rev. Stat. Ann. § 13-1802 (Supp. 1972-73), § 12-2235 (1956).

**Arkansas:** Ark. Stat. Ann. § 28-607 (Repl. Vol. 1962).

**California:** Cal. Evid. Code Ann. § 992 (West Supp. 1972).

**Colorado:** Colo. Rev. Stat. Ann. § 154-1-7 (1964).

**District of Columbia:** D.C. Code Encycl. Ann. § 14-307 (1966).

<sup>93</sup> However, see *Application of Larchmont Gables*, 188 Misc. 164, 64 N.Y.S. 2d 623 (1946), hospital ordered to permit examination of record without disclosing confidential communications.

<sup>94</sup> The privilege arises only where a physician-patient relationship can be established: *Commonwealth v. Sykes*, 353 Pa. 392, 45 A. 2d 43 (1946); likewise only data which is pathologically germane to the patient's treatment is protected: *In re Avery's Estate*, 76 N.Y.S. 2d 790 (Surr. Ct., Madison County 1948). In addition, the privilege applies only in certain types of actions: *In re Albert Lindley Lee Memorial Hospital*, 209 F. 2d 122 (2d Cir. 1953); *State v. Bounds*, 74 Idaho 136, 258 P. 2d 751 (1953); *Commonwealth v. Edward*, 318 Pa. 1, 178 A. 20 (1935); *Mohr v. Mohr*, 119 W.Va. 253, 193 S.E. 121 (1937); but note *New York City Council v. Goldwater*, 284 N.Y. 296, 31 N.E. 2d 31 (1940).

The patient may be deemed to have waived the privilege. See *Heaston v. Krieg*, 167 Ind. 101, 77 N.E. 805 (1906); *Thompson v. Ish*, 99 Mo. 160, 12 S.W. 510 (1889); *Yow v. Pittman*, 241 N.C. 69, 84 S.E. 2d 297 (1954).



- Hawaii:** Hawaii Rev. Stat. § 621-20 (1968).
- Idaho:** Idaho Code § 9-203 (Supp. 1972).
- Illinois:** Ill. Ann. Stat. tit. 51, § 5.1 (Smith-Hurd 1966).
- Indiana:** Ind. Ann. Stat. § 2-1714 (1968).
- Iowa:** Iowa Code Ann. § 622.10 (Supp. 1973).
- Kentucky:** Ky. Rev. Stat. Ann. § 213.200 (1972).
- Louisiana:** La. Rev. Stat. Ann. § 15:476 (1967).
- Michigan:** Mich. Comp. Laws Ann. § 600.2157 (1968).
- Minnesota:** Minn. Stat. Ann. § 595.02 (Supp. 1973).
- Mississippi:** Miss. Code Ann. § 1697 (Supp. 1972).
- Missouri:** Mo. Ann. Stat. § 491.060 (1952).
- Montana:** Mont. Rev. Codes Ann. § 93-701-4 (1964).
- Nebraska:** Neb. Rev. Stat. § 25-1206 (1965).
- Nevada:** Nev. Rev. Stat. §§ 49.215 to 49.245 (1971).
- New Jersey:** N.J. Rev. Stat. §§ 2A:84A-22.1 and 2A:84A-22.2 (Supp. 1972-73).
- New Mexico:** N.M. Stat. Ann. § 20-1-12 (Repl. Vol. 1970).
- New York:** N.Y. Civ. Prac. Act, Rule 4504 (McKinney Supp. 1972-73).
- North Carolina:** N.C. Gen. Stat. § 8-53 (Repl. Vol. 1969).
- North Dakota:** N.D. Cent. Code § 31-01-06 (Supp. 1971).
- Ohio:** Ohio Rev. Code Ann. § 2317.02 (Baldwin 1971).
- Oklahoma:** Okla. Stat. Ann. tit. 12, § 385 (1960).
- Oregon:** Ore. Rev. Stat. § 44.040 (Repl. Part 1971).
- Pennsylvania:** Pa. Stat. Ann. tit. 28, § 328 (1958).
- South Dakota:** S.D. Compiled Laws Ann. § 19-2-3 (1969).
- Utah:** Utah Code Ann. § 78.24-8 (1953).
- Virginia:** Va. Code Ann. § 8-289.1 (Supp. 1972).
- Washington:** Wash. Rev. Code § 5.60.060 (Supp. 1972).

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**West Virginia:** W.Va. Code Ann. § 50-6-10 (1966).

**Wisconsin:** Wis. Stat. Ann. § 325.21 (1958).

**Wyoming:** Wyo. Stat. Ann. § 1-139 (1959).

**APPENDIX B**  
**STATUTES RELATING TO ADMISSIBILITY**  
**OF BUSINESS RECORDS**

**Alabama:** Ala. Code Ann. § 7-415 (1960).

(See also § 7-383(1) relating specifically to the admissibility of hospital records.)

**Arizona:** Ariz. Rev. Stat. Ann. § 12-2262 (1956).

**Arkansas:** Ark. Stat. Ann. §§ 28-928, 28-929 (Repl. Vol. 1962).

**California:** Cal. Evid. Code Ann. §§ 1270 to 1272 (West 1966).

**Connecticut:** Conn. Gen. Stat. Ann. § 52-180 (Supp. 1972-73).

**Delaware:** Del. Code Ann. tit. 10, § 4310 (1953).

**Florida:** Fla. Stat. Ann. § 92.36 (Supp. 1973).

**Georgia:** Ga. Code Ann. § 38-711 (1954).

**Hawaii:** Hawaii Rev. Stat. § 622-4 (1968).

**Idaho:** Idaho Code Ann. §§ 9-413 to 9-416 (1948).

**Indiana:** Ind. Ann. Stat. §§ 2-1656 to 2-1658 (1968).

**Iowa:** Iowa Code Ann. §§ 622.28 to 622.30 (Supp. 1973).

**Kansas:** Kan. Stat. Ann. § 60-460 (1964).

**Maine:** Me. Rev. Stat. Ann. tit. 16, § 457 (1965).

**Maryland:** Md. Ann. Code art. 35, § 59 (1971).

**Massachusetts:** Mass. Gen. Laws Ann. ch. 233, § 78 (1959).

**Michigan:** Mich. Comp. Laws Ann. § 600.2146 (1968).

**Minnesota:** Minn. Stat. Ann. §§ 600.01 to 600.04 (1947).

**Mississippi:** Miss. Code Ann. § 1761.5 (Supp. 1972).

**Missouri:** Mo. Ann. Stat. §§ 490.660 to 490.690 (1952).

- Montana:** Mont. Rev. Codes Ann. §§ 93-801-1 to 93-801-4 (1964).
- Nebraska:** Neb. Rev. Stat. §§ 25-12108 to 25-12111 (1965).
- Nevada:** Nev. Rev. Stat. § 51.135 (1971).
- New Hampshire:** N.H. Rev. Stat. Ann. §§ 521:1 to 521:5 (1955).
- New Jersey:** N.J. Stat. Ann. §§ 2A:82-34 to 2A:82-37 (1952).
- New Mexico:** N.M. Stat. Ann. § 20-2-12 (Repl. Vol. 1970).
- New York:** N.Y. Civ. Prac. Act, Rule 4518 (McKinney 1963).
- North Dakota:** N.D. Cent. Code § 31-08-01 (1968).
- Ohio:** Ohio Rev. Code Ann. §§ 2317.40, 2317.41 (Baldwin 1971).
- Oregon:** Ore. Rev. Stat. §§ 41.680 to 41.710 (Repl. Part 1971).
- Pennsylvania:** Pa. Stat. Ann. tit. 28, §§ 91a to 91d (1958).
- Rhode Island:** R.I. Gen. Laws Ann. § 9-19-13 (1970).
- South Dakota:** S.D. Compiled Laws Ann. § 19-7-11 (1969).
- Tennessee:** Tenn. Code Ann. §§ 24-712 to 24-715 (Supp. 1972).
- Texas:** Tex. Rev. Civ. Stat. Ann. art. 3737e, §§ 1 to 4 (Supp. 1972-73).
- Vermont:** Vt. Stat. Ann. § 1700 (1958).
- Washington:** Wash. Rev. Code §§ 5.45.010 to 5.45.920 (1963).
- Wisconsin:** Wis. Stat. Ann. § 889.25 (1966).
- Wyoming:** Wyo. Stat. Ann. §§ 1-170 to 1-173 (1959).
- Federal:** U.S. Code Ann. tit. 28, § 1732 (1966).

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## MEDICAL RECORDS

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- ¶ 1-2 Legal Requirements
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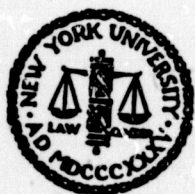
#### APPENDIX A—CONFIDENTIAL COMMUNICATIONS STATUTES

#### APPENDIX B—STATUTES RELATING TO ADMISSIBILITY OF BUSINESS RECORDS



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# Annual Survey of American Law



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## PATIENTS' RIGHTS

### DISCLOSURE, CONSENT AND CAPACITY

NIKKI HEIDPRIEM  
JUDITH RESNIK

THE recent Supreme Court decision invalidating state abortion statutes,<sup>1</sup> the much-publicized Michigan psychosurgery decision,<sup>2</sup> the growing number of right to treatment cases,<sup>3</sup> and the issuance of federal guidelines protecting minors and other legally incompetent participants in federally funded sterilization programs<sup>4</sup> have prompted a reconsideration of the personal rights of patients within the physician-patient-state relationship. Recent malpractice cases reveal an innovative trend in tort law expanding the physician's duty to disclose information to a patient in order to obtain that patient's informed consent.<sup>5</sup> This article will discuss several of the complex issues associated with the physician-patient relationship: how courts define the physician's duty to disclose under the present law, when informed consent is required; when an adult is deemed incompetent by the state to give such consent, and what special considerations arise as incidents of minority.

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Ms. Nikki Heidepriem and Ms. Judith Resnik are staff members of the *Annual Survey of American Law*. Ms. Heidepriem wrote "Minors' Capacity to Consent to Health Care." Ms. Resnik wrote "The Physician's Duty to Disclose" and "The Elements of Consent: A Case Study—Mentally Ill Patients."

1. *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973).

2. *Kaimowitz v. Michigan Dep't of Mental Health*, Civil No. 73-19434-AW (Mich. Cir. Ct. July 10, 1973), noted at 42 U.S.L.W. 2063. See notes 105-54 infra and accompanying text.

3. See, e.g., *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), appeal pending, No. 72-2634 (5th Cir. 1972), as discussed in *Civil Rights*, 1972/73 *Ann. Survey Am. L.* 339, 371-74.

4. See Dep't Health, Educ. & Welfare, "General Guidelines Limiting Federal Financial Assistance for Sterilization of Minors and Other Legally Incompetent Individuals," News Release, July 19, 1973. Formal regulations were issued September 21, 1973. 38 Fed. Reg. 26460 (Sept. 21, 1973). See *N.Y. Times*, Sept. 21, 1973, at 46, col. 3. Congress has also recently considered legislation to protect patients' rights. *N.Y. Times*, Sept. 17, 1973, at 34, col. 1, and Sept. 27, 1973, at 13, col. 1. See also draft of "Protection of Human Subjects: Policies and Procedures" 38 Fed. Reg. 31738 (Nov. 16, 1973).

5. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), cert. denied, 409 U.S. 1064 (1972), analyzed in text accompanying notes 6-43 infra; *Wilkinson v. Vesey*, 110 R.I. —, 295 A.2d 676 (1972), analyzed in text accompanying notes 44-60 infra; and *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972), analyzed in text accompanying notes 61-73 infra. See generally Note, *Informed Consent—A Proposed Standard for Medical Disclosure*, 48 N.Y.U.L. Rev. 548 (1973), for a breakdown of the classic elements of this kind of tort action. *Id.* at 549. For an earlier discussion of this topic, see *Torts*, 1966 *Ann. Survey Am. L.* 209, 231-33.



## I

## THE PHYSICIAN'S DUTY TO DISCLOSE

In 1972, the United States Court of Appeals for the District of Columbia Circuit in its decision in *Canterbury v. Spence*<sup>6</sup> forcefully asserted the rights of a patient to determine what should be done with his or her body.

Plaintiff Jerry Canterbury, a nineteen-year-old boy, had submitted to an operation performed by the defendant, a surgeon, without being told that there was a minimal risk of paralysis<sup>7</sup> associated with the procedure.<sup>8</sup> The plaintiff alleged that the defendant was negligent in his performance of the operation and in his failure to inform his patient of the risk involved. The doctor claimed that it was not good medical practice to communicate such risks because such knowledge might deter patients from undergoing needed surgery.<sup>9</sup> Circuit Judge Spottswood Robinson III,

6. 464 F.2d 772 (D.C. Cir. 1972). The *Canterbury* interpretation of patients' rights may well conflict with the Supreme Court's most recently expressed views on the issue in *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973). In both *Roe* and *Doe* the Court concluded that the constitutionally protected right of privacy encompassed a woman's decision to terminate her pregnancy, but held that this right was nevertheless subject to the state's interest in safeguarding health. 410 U.S. at 154-63. Justice Blackmun relied upon two earlier Supreme Court decisions, one upholding the state's power to require vaccination, *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), and another upholding the state's power to sterilize congenitally defective persons, *Buck v. Bell*, 274 U.S. 200 (1927), to determine that the Court did not recognize an "unlimited right" to do "with one's body as one pleases." 410 U.S. at 154. The Court explicitly made the abortion decision a "medical" one, even during the first trimester, by placing responsibility with the physician:

This means, on the other hand, that, for the period of pregnancy prior to this "compelling" point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that in his medical judgment the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State. 410 U.S. at 163 (emphasis added). See *id.* at 166. This concept is fundamentally contrary to *Canterbury*, which purposefully located final decision-making power in the patient. 464 F.2d at 780.

Similarly, in *Doe v. Bolton*, 410 U.S. 179 (1973), Justice Blackmun held that the hospital review committee, required by Georgia's abortion statute, was unconstitutional in that it invaded the doctor's right to administer medicine and the woman's right to receive care in accordance with her physician's best judgment. 410 U.S. at 197. Only Justice Douglas, in his concurring opinion in *Doe*, suggested that there was a strong constitutional basis for personal health rights in addition to their traditional common law foundations. *Id.* at 213. See also *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914), overruled on other grounds, *Bing v. Thunig*, 39 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

7. The risk of paralysis inured in the procedure (464 F.2d at 779) and therefore required a warning. The plaintiff's condition, however, may also have been caused by a trauma resulting from an accidental fall during the post-operative period. *Id.* at 778.

8. *Id.* at 777. In *Canterbury*, the risk was assessed at approximately "one percent." *Id.* at 778. It must be noted that the significance of any risk varies with the potential injury and the expected gain. Thus, the actual numeric figure attached to the risk is without independent meaning.

9. *Id.*

reversing the defendant's directed verdict and remanding the case for a new trial, held that the plaintiff had made a *prima facie* case of the physician's violation of his duty to disclose, and that it remained for a jury to decide whether such failure actually caused the plaintiff's injury.<sup>10</sup>

The court relied on what it deemed a "fundamental" principle of American jurisprudence that "every human being of adult years and sound mind has a right to determine what shall be done with his body. . . ."<sup>11</sup> In order to exercise the right to choose, the patient is dependent upon the physician to inform him or her of the benefits, risks<sup>12</sup> and alternatives available.<sup>13</sup> Hence, the law requires "reasonable divulgence"<sup>14</sup> by the physician as to each of these factors whenever a question arises as to whether a "particular treatment procedure"<sup>15</sup> should be undertaken.<sup>16</sup>

The *Canterbury* decision is particularly significant because, in addition to recognizing the commonplace duty to disclose,<sup>17</sup> it rejected outright the prevailing judicial practice of requiring expert medical testimony to define what constitutes acceptable physician-patient communication.<sup>18</sup> The court concluded that no consensus existed on this issue within the medical profession,<sup>19</sup> that each case presented such different circumstances

10. *Id.* at 779.

11. *Id.* at 780, quoting Cardozo, J., in *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

12. The duty to disclose encompasses potential or collateral dangers as well as inherent ones. 464 F.2d at 782.

13. *Id.* at 780, 782.

14. In distinguishing the "duty of disclosure" from the doctrine of "informed consent," the court noted that the focus in disclosure cases must be on the reasonableness of the extent of the physician's effort to communicate information, rather than on the patient's comprehension of the situation. *Id.* at 780 n.15. Furthermore, the physician's duty exists whether or not the patient has asked for any information. As the court phrased it, "[c]aveat emptor is not the norm for the consumer of medical services." *Id.* at 783 n.36.

15. The phrase "particular treatment procedure" includes but is not limited to surgery; the duty to disclose arises before commencement of any medical treatment, and implicitly extends to the risks of medications, physical therapies, and other non-surgical procedures. See *id.* at 781. The requirement thus goes beyond the procedures for which a physician normally obtains written consent. See, e.g., the consent forms presented in *Morris, Crawford, and Morritz, Doctor and Patient and the Law* 170-80 (5 ed. 1971). Accord, *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Wilkinson v. Vesey*, 110 R.I. \_\_\_, 295 A.2d 676 (1972).

16. 464 F.2d at 782.

17. See, e.g., *Dunham v. Wright*, 423 F.2d 940, 943-46 (3d Cir. 1970) (applying Pennsylvania law); *Campbell v. Oliva*, 424 F.2d 1244, 1250-51 (6th Cir. 1970) (applying Tennessee law).

18. 464 F.2d at 783. Compare *Haven v. Randolph*, 342 F. Supp. 538 (D.D.C. 1972), decided one day before *Canterbury* and requiring expert testimony on the disclosure issue. See *Natanson v. Kline*, 187 Kan. 186, 354 P.2d 670 (1960), discussed in text accompanying notes 74-78 *infra*. See also *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965) (holding that expert testimony is required on this issue); *Washington Hosp. Center v. Batter*, 384 F.2d 331 (D.C. Cir. 1967); *Ze Barth v. Swedish Hosp. Medical Center*, 81 Wash. 2d 12, 499 P.2d 1, 52 A.L.R.3d 1067 (1972).

19. 464 F.2d at 783.



that a search for a general custom was inappropriate,<sup>20</sup> and that the rights of patients "demand[ed]" a standard set "by law for physicians rather than one which physicians may or may not impose upon themselves."<sup>21</sup>

Having rejected the general method of determining the scope of a doctor's duty to disclose,<sup>22</sup> the court substituted its own test dictated by the "patient's need":<sup>23</sup> a physician must convey to a patient all material information the latter needs to make an "intelligent" decision (*i.e.*, the inherent and potential hazards of the treatment,<sup>24</sup> the alternatives to the treatment, and the results of non-treatment).<sup>25</sup> The court proposed that the jury consider whether all "material"<sup>26</sup> information had been conveyed and whether a reasonable person<sup>27</sup> would have been "likely to [have] attach[ed] significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."<sup>28</sup>

*Canterbury* also redefined the two long-standing exceptions to the rule of disclosure. The first exception was identified as the "emergency" situation which exists only when a person is unconscious or otherwise incapable of consenting to treatment,<sup>29</sup> when the failure to treat would result in imminent harm, and when the harm threatened outweighs any harm of the proposed treatment.<sup>30</sup> Before performing any procedure, the physician must attempt to secure the consent of a relative of the patient if possible.<sup>31</sup> The court explained that while expert testimony of common

20. *Id.* at 784. The court did not preclude introduction of evidence of professional custom but explained that such testimony cannot "furnish the test for" the standard of care. *Id.* at 785.

21. *Id.* at 784.

22. See cases cited in note 18 *supra*.

23. *Id.* at 786. "[T]he patient's right of self-decision shapes the boundaries of the duty to reveal." *Id.*

24. *Id.* at 782. See note 8 *supra*. Statistically small risks would not automatically be excluded from disclosure. *Id.* at 788.

25. *Id.* at 787-88. Compare Note, Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship, 79 *Yale L.J.* 1533 (1970) [hereinafter cited as Restructuring Informed Consent], cited with approval, 464 F.2d at 783 n.36.

26. 464 F.2d at 786. The *Canterbury* court never formulated a precise definition of the word "material." The court noted that individual insignificant risks may achieve materiality in combination (*id.* at 788 n.89); nonetheless a physician need not communicate information of which an average person already would be aware or that would be of no "apparent materiality." *Id.* at 788.

27. Reasonable in "what the physician knows or should know to be the patient's position." *Id.* at 787.

28. *Id.* at 787, quoting Waltz & Scheuneman, Informed Consent to Therapy, 64 *Nw. U.L. Rev.* 628, 640 (1970).

29. 464 F.2d at 788. Interestingly, the court never defined the characteristics of "a patient incapable of giving consent." See *id.* at 782 n.32. See also notes 105 & 115-39 *infra* and accompanying text.

30. *Id.* at 788. It is unclear whether an "emergency" is limited to situations where a patient's life is endangered. Cf. the broader definition of "emergency" in N.Y. Pub. Health Law § 2504(5) (McKinney Supp. 1975).

31. 464 F.2d at 789.



medical practice is relevant, it is not controlling in proving the existence of such an emergency.<sup>32</sup>

The second exception is the "therapeutic privilege," under which a physician may withhold information from any patient whom the doctor believes is so distraught that disclosure would be detrimental to his well-being.<sup>33</sup> After criticising the grant of such wide discretion,<sup>34</sup> the court carefully circumscribed this privilege by placing upon the defendant-physician the burden of proof that the privilege was properly exercised.<sup>35</sup> In assessing the propriety of the physician's use of the privilege, the physician's decision alone is insufficient legal support; rather, there must be independent evidence of the patient's emotionally unstable condition and of disclosure to one of his relatives.<sup>36</sup>

Under *Canterbury*, the plaintiff has the burden of going forward with evidence as well as the burden of proof to show that the physician failed to disclose material information and thereby caused the plaintiff's injury.<sup>37</sup> The court explained that the requisite causal connection can exist only when the jury finds that a prudent person in circumstances similar to the plaintiff-patient<sup>38</sup> would have declined treatment had he known of the risks involved.<sup>39</sup> Each of these elements may be proved successfully without any expert testimony.<sup>40</sup> The court, however, did recognize a possible need to call expert witnesses to give opinions on technical medical questions or on the existence of an exception to the disclosure rule.<sup>41</sup> Finally, the court protected the rights of patients by classifying the physician's omissions as negligence, rather than the intentional tort of battery,<sup>42</sup> thereby giving the plaintiff the benefit of the longer statute of limitations.<sup>43</sup>

32. *Id.*

33. *Id.*

34. *Id.* Many legal commentators share the court's disfavor. See, e.g., Restructuring Informed Consent, *supra* note 23, at 1535. For the moral and ethical arguments in favor of full disclosure from a physician's point of view, see J. Fletcher, *Morals and Medicine*, ch. 2 (1960).

35. 464 F.2d at 791.

36. See *id.* at 791, 794.

37. *Id.* at 791. However, the physician has the burden of going forward with evidence pertaining to the existence of a privilege. *Id.*

38. The court detailed the distinction between the "objective" test it had chosen and the alternative of a "subjective" test. *Id.* at 790-91. See W. Prosser, *The Law of Torts* § 52, at 149-50 (4th ed. 1971).

39. 464 F.2d at 791. Thus the testimony of the plaintiff is relevant but not dispositive of this causality element. The "materiality" of the information withheld will actually be the most crucial factor to a finding of negligence in the physician's non-disclosure.

40. *Id.* at 791-92 & n.124. See generally notes 17-21 *supra* and accompanying text.

41. *Id.* at 791-92.

42. *Id.* at 793.

43. But see *Ray v. Scheibert*, \_\_\_\_ Tenn. App. \_\_\_\_, 484 S.W.2d 33 (1972) (plain-

*Canterbury* represent a considerable movement away from traditional physician privileges and creates substantial rights of self-determination for patients. The District of Columbia court's thoughtful discussion of these issues was soon followed by two state supreme court decisions in Rhode Island and California.

In *Wilkinson v. Vesey*,<sup>44</sup> the plaintiff, who had received extensive x-ray treatment for a "shadow" in her chest, and who subsequently had eight operations to graft skin and remove much of her thoracic structure, claimed that her physicians were negligent in their diagnosis, their administration of the treatment and their failure to obtain her knowing consent prior to treatment.<sup>45</sup> The Supreme Court of Rhode Island reversed a lower court's directed verdict for the defendant-physicians and held that the plaintiff had presented sufficient evidence to send her case to the jury.<sup>46</sup> Reminiscent of *Canterbury*, the court held that the physicians' failure to obtain knowing consent gave rise to a claim of negligence;<sup>47</sup> that expert testimony, while relevant, would not be determinative of such a claim;<sup>48</sup> that a decision to undergo treatment is the patient's

tiff's suit barred by the statute of limitations because a physician's failure to adequately inform his patient was held to constitute a battery).

There are other ramifications of pleading a claim of battery rather than a claim of negligence. To prove battery, the patient must show that the physician "touched" him without authorization. The touching itself is the injury and entitles the "victim" to punitive or nominal damages as well as consequential damages for actual resulting harm. A physician's malpractice insurance may not cover liability arising from an intentional tort. See *Cobbs v. Grant*, 8 Cal. 3d 229, 240, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972), discussed in text accompanying notes 61-73 *infra*. For an enumeration of the elements of the negligence cause of action, see Note, Informed Consent—A Proposed Standard for Medical Disclosure, 48 N.Y.U.L. Rev. 548, 549-51 (1973). For elaboration of the differences between negligence and battery actions, see, e.g., McCold, A Reappraisal of Liability for Unauthorized Medical Treatment, 41 Minn. L. Rev. 381, 423-25 (1957), and other articles cited in 464 F.2d at 793 n.130. It has been argued, however, that when expert testimony determines the standard for measuring a physician's duty of disclosure, it makes little substantive difference (beyond the distinction in applicable statutes of limitations) whether the plaintiff's suit is in battery or negligence. See Restructuring Informed Consent, *supra* note 25, at 1557 n.67. Fraud offers a third possible cause of action. Such a suit requires proof that the physician knowingly misled the patient to induce him or her to consent. See, e.g., *Lopez v. Swyer*, 115 N.J. Super. 237, 279 A.2d 116 (1971).

44. 110 R.I. \_\_\_, 295 A.2d 676 (1972). There had also been an earlier decision in the case holding that the statute of limitations did not bar the action. *Wilkinson v. Harrington*, 104 R.I. 224, 243 A.2d 745 (1968).

45. 110 R.I. at \_\_\_, 295 A.2d at 681.

46. 110 R.I. at \_\_\_, 295 A.2d at 681, 685.

47. The court distinguished its own earlier ruling *Nolan v. Kechijian*, 75 R.I. 165, 64 A.2d 866 (1949), and held that recovery for the intentional tort of battery was appropriate only when the "procedure is completely unauthorized"; inadequate disclosure, in contrast, raised a claim of negligence. 110 R.I. at \_\_\_, 295 A.2d at 686. See also note 43 *supra*.

48. 110 R.I. at \_\_\_, 295 A.2d at 687-88. The court used the *Canterbury* rationale to eliminate the need for expert testimony. See notes 17-21, 40 & 41 *supra* and accompanying text.



undeniable right;<sup>49</sup> and that local medical community practice does not set the standard for sufficient disclosure.<sup>50</sup> Further paralleling *Canterbury*, *Wilkinson* held that adequacy of disclosure should be determined by a jury on the basis of the "materiality" of the facts;<sup>51</sup> thus the physician has no duty to disclose those risks a patient is likely to or actually does know on the basis of past experience.<sup>52</sup> Also as in *Canterbury*, one of the elements of the plaintiff's case is proof that, had he been duly informed of the risk of the procedure, he would not have given his consent.<sup>53</sup>

The *Wilkinson* opinion, however, deviates from *Canterbury* in a few respects.<sup>54</sup> *Wilkinson's* extremely strong language, apparently granting the patient an absolute right of choice, goes somewhat beyond the *Canterbury* holding, which took careful account of the emergency situation.<sup>55</sup> Further, the Rhode Island court addressed the problem of adversity between the physician and patient on the necessity of the disclosure.<sup>56</sup> Third,

49. *Id.* at \_\_\_\_, 295 A.2d at 688.

50. *Id.* at \_\_\_\_, 295 A.2d at 688. See Torts, 1973/74 Ann. Survey Am. L. 131.

51. 110 R.I. at \_\_\_\_, 295 A.2d at 688-89, also citing Waltz & Scheuneman, *supra* note 23, at 640, for the definition of "materiality."

52. 110 R.I. at \_\_\_\_, 295 A.2d at 689, and cases cited therein.

53. *Id.* at \_\_\_\_, 295 A.2d at 690. In addition, the Rhode Island court proffered an argument (derived from 2 F. Harper & F. James, *Law of Torts* § 17.1 n.15 (Supp. 1968)), which distinguished the usual malpractice cases, where the physician and patient share the common goal of effecting a cure, from the duty-to-disclose cases, where the views of the physician and patient might be divergent. The patient may object to the physician's suggested treatment because risks in the patient's view outweigh the advantages. The *Wilkinson* court stated definitively that every competent [adult has the] right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession, or even the community.

110 R.I. at \_\_\_\_, 295 A.2d at 687. Accord, *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962) (final authority rested with the patient to refuse a life-saving blood transfusion). While the court failed to deal with the emergency situation (compare *Canterbury*, discussed in notes 29-32 *supra* and accompanying text), Harper and James propose that in a situation where an adult, voluntarily hospitalized, refuses life saving treatment, his desire should prevail. Harper & James, *supra*. But see *Application of President and Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964) upholding hospital's administration of a life saving blood transfusion to an objecting adult patient who was a Jehovah's Witness; *Jehovah's Witnesses of Wash. v. King County Hosp.*, 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd per curiam*, 390 U.S. 598 (1968). *John F. Kennedy Mem. Hosp. v. Heston*, 58 N.J. 576, 580, 279 A.2d 670, 672 (1973). For discussion of an adult's first amendment right to refuse medical treatment see Note, *Compulsory Medical Treatment and the Free Exercise of Religion*, 42 Ind. L.J. 386 (1967).

54. See 110 R.I. at \_\_\_\_, 295 A.2d at 688, where the court states that its reasoning is different from *Canterbury's*.

55. 464 F.2d at 788-89. *Wilkinson* only mentioned the emergency situation incidentally, quoting *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), which restricted such situations to times when a patient is unconscious and in need of immediate surgery.

56. 110 R.I. at \_\_\_\_, 295 A.2d at 687. See note 53 *supra*.

the *Wilkinson* decision arguably extended *Canterbury* by imposing the burden of disclosure upon *all* physicians of the treatment team.<sup>57</sup> Also, the Rhode Island court never explicitly assigned the burden of proof of the validity of non-disclosure.<sup>58</sup> This distinction between the opinions, however, may be only superficial since the language in *Wilkinson* suggests that, as in *Canterbury*, a rebuttable presumption of negligence arises once the plaintiff has demonstrated the physician's failure to disclose material facts.<sup>59</sup> Finally, in contrast to both *Canterbury's* careful discussion and *Wilkinson's* own generally broad statement of patients' rights, the Rhode Island court left a potential "loophole" in its protection by merely noting the therapeutic privilege doctrine without defining its scope or appropriate application.<sup>60</sup>

The third major decision on a doctor's duty to disclose was issued seven days after *Wilkinson* by the Supreme Court of California sitting en banc in *Cobbs v. Grant*.<sup>61</sup> In *Cobbs*, defendant-physician appealed a jury's general verdict of negligence as unsupported by the evidence and challenged the trial court's instructions on informed consent.<sup>62</sup> The Supreme Court of California held that, in the face of medical facts "not commonly susceptible of comprehension by a lay juror," plaintiff's failure to introduce expert testimony in support of his claim of negligence by a physician for performance of surgery required a reversal of the judgment.<sup>63</sup> Because

57. *Id.* at \_\_\_\_ 295 A.2d at 689. In *Wilkinson*, a radiologist was included within this zone of duty. *Canterbury* probably failed to deal with this issue because the complaint at bar had named only one defendant, the operating surgeon. This oversight is unfortunate since it leaves open the question of who must make disclosures when treatment involves more than one physician.

58. Compare *Canterbury*, 464 F.2d at 791, placing this burden on the physician. See note 37 *supra* and accompanying text.

59. 110 R.I. at \_\_\_\_ 295 A.2d at 688.

60. The court simply stated:

The imposition of a duty of making disclosure is tempered by the recognition that there may be a situation where a disclosure should not be made because it would unduly agitate or undermine an unstable patient.

*Id.* at \_\_\_\_ 295 A.2d at 689. See also Univ. of Pa. Health Law Project, 8 Materials on Health Law, 34 (unpublished, rev'd ed. 1972). See also notes 33-36 *supra* and accompanying text.

61. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972). The patient, Cobbs, suffered various infectious complications, requiring repeated surgery, which had arisen from the removal of a duodenal ulcer. Although Cobbs had consented to the initial surgery at the recommendation of his family doctor and the defendant surgeon, Dr. Grant, neither physician had warned him of the inherent risks in the operation. *Id.* at 234, 502 P.2d at 4, 104 Cal. Rptr. at 508.

62. *Id.* at 236, 502 P.2d at 5, 104 Cal. Rptr. at 509. For an earlier decision in the case on a different issue, see 100 Cal. Rptr. 98 (Cal. App. 1972).

63. 8 Cal. 3d at 236, 502 P.2d at 5, 104 Cal. Rptr. at 509. The court refused to find that this case fit within the "common knowledge exception." *Id.* at 237, 502 P.2d at 5-6, 104 Cal. Rptr. at 509. Compare *Canterbury*, 464 F.2d at 791-92, where the District of Columbia court also recognized the need for medical (expert) testimony for certain purposes such as determining the "risks of therapy and the consequences of leaving existing maladies untreated." *Id.* See note 41 *supra* and accompanying text.

the jury had rendered a general verdict and the grounds for liability could have been either negligence in his decision to operate or in his performance of the surgery, or alternatively, failure to obtain informed consent, the court remanded the case for a new trial. Recognizing that the question of informed consent would probably arise on retrial, the court expounded guidelines similar to the *Canterbury* standards for instructing the jury.<sup>64</sup> The court further clarified California law by effectively following *Canterbury* and *Wilkinson* to hold that failure to make adequate disclosure may lead to a claim of negligence.<sup>65</sup> The physician owes his patients a "duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each."<sup>66</sup> Fulfillment of such duty should be measured by general community, rather than medical, standards of reasonableness.<sup>67</sup> In viewing the physician-patient relationship as "fiducial" rather than paternalistic,<sup>68</sup> the court held that the patient's need for information measures the scope of the physician's duty.<sup>69</sup> While summarily recognizing the traditional exceptions to the above rule in cases where an emergency exists<sup>70</sup> or where

64. 8 Cal. 3d at 234, 502 P.2d at 4, 104 Cal. Rptr. at 508. See also *Canterbury*, 464 F.2d at 786.

65. 8 Cal. 3d at 240, 502 P.2d at 8, 104 Cal. Rptr. at 512. Battery was restricted to "those circumstances when a doctor performs an operation to which the patient has not consented." *Id.* See *Berkey v. Anderson*, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969) (failure to disclose risks inherent in an exploratory surgical operation could constitute a technical battery). Cf. *Dow v. Kaiser Foundation*, 12 Cal. App. 3d 488, 90 Cal. Rptr. 747 (1970) (proof of willfully withheld material information without good medical reason is required to establish the claim of battery); *Carmichael v. Reitz*, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971) (failure to disclose constituted negligence). The trend in other jurisdictions is not yet uniform. See, e.g., *Ray v. Scheibert*, \_\_\_\_ Tenn. App. \_\_\_\_, 484 S.W.2d 63 (1972). See note 43 *supra*.

66. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514. The court explicitly protected physicians for non-disclosure of minor or commonly known risks with relatively uncomplicated procedures. 8 Cal. 3d at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515. Cf. note 15 *supra*. Compare *Canterbury*, 464 F.2d at 788, which, while excepting commonly known risks or those risks of which the patient is already aware, refused to limit the rule according to the size of the probability of the hazard occurring or the complexity of the procedure.

67. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514. The court used reasoning similar to that in *Canterbury*, 464 F.2d at 782, and *Wilkinson*, 110 R.I. at \_\_\_\_, 295 A.2d at 687. *Cobbs* rejected the prevailing "medical community" standards rule as "needlessly overbroad" because it gave "virtual absolute discretion" to the physician. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

68. 8 Cal. 3d at 246, 502 P.2d at 12, 104 Cal. Rptr. at 516.

69. *Id.* at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515, quoting *Canterbury*, 464 F.2d at 786, using the "materiality" standard.

70. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514. *Cobbs* did not define the term "emergency" (but see *Canterbury*, 464 F.2d at 788), but held that when such a situation occurs, consent may be implied. Compare treatment of this issue in *Wilkinson* where the court merely alluded to the problem. 110 R.I. at \_\_\_\_, 295 A.2d at 685.



the patient is a minor or incompetent,<sup>71</sup> the *Cobbs* court expressly tried to narrow the California interpretation of therapeutic privilege by placing the burden of proof as to its applicability upon the physician.<sup>72</sup> Finally, under *Cobbs*, as in *Canterbury* and *Wilkinson*, the plaintiff must prove that, had he known the risks, he would have foregone the treatment.<sup>73</sup>

As demonstrated by the foregoing summary, *Canterbury*, *Wilkinson*, and *Cobbs* represent a significant change in tort law. The magnitude of the departure is highlighted by a comparison of these three cases with *Natanson v. Kline*,<sup>74</sup> the landmark decision prior to *Canterbury* on physicians' duty to disclose. Decided by the Supreme Court of Kansas in 1960, *Natanson* imposed a legal duty on physicians to make reasonable disclosures to patients concerning the inherent hazards of a given treatment<sup>75</sup> and held that a doctor who had told his patient nothing of the risks of cobalt treatment failed as a matter of law in his duty towards her.<sup>76</sup> *Natanson* provided that the jury, as laymen, should decide whether any disclosure was made; but, in contrast to the 1972 decisions,<sup>77</sup> the adequacy of that disclosure was held to turn on reasonable medical practice and therefore necessitated expert testimony.<sup>78</sup>

Possible explanations for the change in judicial orientation since *Natanson* are the articulation of new theories in the areas of patients' rights and tort law, and the recognition of the need to divest the physician of some of his unlimited power over a patient's body. Each of the 1972 decisions has as its implicit purpose the alleviation of plaintiffs' problems

71. 8 Cal. 3d at 244, 502 P.2d at 10, 104 Cal. Rptr. at 514. The court failed to define the term "incompetent," but did state that when treating such a patient, the physician must obtain consent from the patient's legal guardian or closest available relative. *Id.*

72. The physician must show by a preponderance of the evidence [that] he relied upon facts which would demonstrate to a reasonable man that disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment.  
8 Cal. 3d at 246, 502 P.2d at 12, 104 Cal. Rptr. at 516. Accord, *Canterbury*, 464 F.2d at 789.

73. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

74. 187 Kan. 186, 354 P.2d 670 (1960).

75. *Id.* at 189, 354 P.2d at 673.

76. *Id.*

77. Only one decision before *Canterbury* had eliminated the requirement of expert testimony on the adequacy of disclosure. In *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962), the Supreme Court of New Mexico held that physicians have a duty to disclose the nature, consequences and risks of treatments and that the sufficiency of any disclosure was an issue for the jury. Unlike *Canterbury*, *Wilkinson* or *Cobbs*, the plaintiff did not have to prove that the undisclosed knowledge would have deterred her from undergoing the therapy. The court may have reached this conclusion, however, as a result of evidence that the physician had affirmatively misled the patient by unwarranted reassuring statements.

78. 187 Kan. at 189, 354 P.2d at 673. Accord, W. Prosser, *The Law of Torts* § 33 (4th ed. 1971).

in securing favorable expert witnesses,<sup>79</sup> and each of the courts apparently were swayed by legal commentators who had criticized the requirement of such testimony.<sup>80</sup> Each opinion aspired to a physician-patient relationship based upon mutual trust.<sup>81</sup> The Supreme Court of Rhode Island epitomized the thesis of these recent decisions in its statement that "more communication between doctor and patient means less litigation between patient and doctor."<sup>82</sup>

While only future applications will demonstrate the true viability of these new guidelines,<sup>83</sup> there are already several points of confusion evident in the decisions.<sup>84</sup> None of the courts detailed disclosure requirements for treatments other than surgery.<sup>85</sup> Although *Cobbs* excludes "common procedures" from the disclosure requirement, no definition of what constitutes such a procedure is formulated.<sup>86</sup> Moreover, the scope of the therapeutic and emergency privileges still remains ill-defined.<sup>87</sup> Finally, these expanded concepts of patients' rights may be difficult to implement in view of the economic realities of the delivery of health care, particularly in clinics where a revolving set of doctors continually meet new patients and administer short-term treatments.<sup>88</sup>

79. *Canterbury*, 464 F.2d at 792; *Wilkinson*, 110 R.I. at \_\_\_, 295 A.2d at 687; *Cobbs*, 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 513. Accord, 2 F. Harper & F. James, *The Law of Torts* § 17.1 n.15 (Supp. 1968).

80. See, e.g., *Canterbury*, 464 F.2d at 779, relying on *Waltz & Scheuneman*, *Informed Consent to Therapy*, supra note 28, and on *Restructuring Informed Consent*, supra note 25, at 1533 (1970); *Wilkinson*, 110 R.I. at \_\_\_, 295 A.2d at 685, 687, relying upon *Waltz & Scheuneman*, supra, *Restructuring Informed Consent*, supra note 25, and *Harper & James*, supra note 79; *Cobbs*, 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514, referring to *Comment*, 75 Harv. L. Rev. 1445 (1962), and *Waltz & Scheuneman*, supra.

81. Cf. *Canterbury*, 464 F.2d at 782; *Wilkinson*, 110 R.I. at \_\_\_, 295 A.2d at 690; *Cobbs*, 8 Cal. 3d at 246, 502 P.2d at 12, 104 Cal. Rptr. at 516.

82. 110 R.I. at \_\_\_, 295 A.2d at 690.

83. For the purposes of this discussion the writers consider the standards promulgated by the three courts to be essentially the same.

84. Many questions inevitably arise from the courts' language formulating the patients' right to informed consent. In addition, consider related questions such as who "owns" or should have access to patients' medical records, if they actually have an expansive right to know? See Dep't of Health, Educ. & Welfare, *Report of the Secretary's Comm'n on Medical Malpractice*, Publication No. (OS) 73-88 (1973) (hereinafter cited as *HEW Report*). See also Univ. of Pa. Health Law Project, 8 *Materials on Health Law* 62 (unpublished, rev'd ed. 1972).

85. Cf. note 15 supra.

86. See note 66 supra.

87. See notes 29-36, 55, 60 & 70-72 supra and accompanying text. See Note, *Consent to Surgery—A Dilemma*, 37 Albany L. Rev. 591 (1973), for a review of inconsistent judicial definitions in New York of the term "emergency."

88. See *HEW Report*, supra note 84, at 3. There are many unanswered practical questions which arise particularly in this context: Do the courts' guidelines achieve the "delicate balance between the right of the patient to choose the treatment he wishes to undergo and the freedom of the physician to practice responsible and progressive medicine without fear of frequent litigation"? (*Dunham v. Wright*, 423 F.2d 940,

The impact of the *Canterbury*, *Wilkinson*, and *Cobbs* decisions has been disappointing thus far since both federal and state courts have relied upon the traditional standards. For example, in a malpractice suit involving a well-known heart specialist, a federal district court in Texas directed a verdict for the defendant and followed earlier Texas law to hold that the duty of a physician to disclose information is measured by the community medical practice.<sup>89</sup> Furthermore, using vague language, the court designed a broad version of the therapeutic privilege permitting "each doctor [to] use his medical judgment as to whether certain disclosures of risks would have an adverse effect on the patient so as to jeopardize the success of the proposed therapy."<sup>90</sup>

A federal district court in Pennsylvania also supported a physician's right to determine the sufficiency of his disclosure to his patients in *Ciccarone v. United States*.<sup>91</sup> While noting that Pennsylvania law required a physician to obtain informed consent, the district court dismissed plaintiff's claim that the physician had negligently discharged this duty, even though he had failed to tell the patient of the alternatives available to the proposed treatment. The court reasoned that it could not "place a doctor in the position of talking a patient out of treatment which he [the physician] reasonably believe[d] to be necessary and safe."<sup>92</sup>

In *Collins v. Itoh*,<sup>93</sup> the Supreme Court of Montana endorsed the discretionary powers of a physician by affirming a directed verdict in favor of a physician-defendant in a malpractice action. The court, in the face of unusually significant omissions by the defendant surgeon, rejected the patient's claim that the physician had breached his duty to disclose.<sup>94</sup> The court held that the plaintiff had failed to produce the expert testi-

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942 (D.C. Cir. 1970), cited in *Canterbury*, 464 F.2d at 780). Has the physician the time to make a disclosure adequate to the courts' requirements? Is there a real opportunity for the patients' right of self-determination to be observed in the pressured atmosphere of a busy urban clinic? How can such a right find expression when health care is economically beyond the reach of some?

89. *Karp v. Cooley*, 349 F. Supp. 827, 833 (S.D. Tex. 1972).

90. *Id.* at 834, quoting earlier Texas cases. The decision, however, may be explained by the facts at bar. The court had heard persuasive testimony that the physicians had explained the nature of the heart surgery in detail to both the deceased patient and his widow, the plaintiff. Furthermore, the plaintiff's credibility was undercut because previously she had been most pleased with the physicians' efforts on her husband's behalf, having written numerous laudatory letters on the subject. 349 F. Supp. at 829-32.

91. 350 F. Supp. 554 (E.D. Pa. 1972).

92. *Id.* at 563.

93. 160 Mont. \_\_\_, 503 P.2d 36 (1972).

94. *Id.* at \_\_\_, 503 P.2d at 40-41. The court's decision is striking because the physician had not only failed to warn the patient, prior to her thyroidectomy, of the potential risks involved, but also post-operatively had withheld the fact that during the operation he had inadvertently removed the parathyroid (four small endocrine glands located adjacent to the thyroid). *Id.*, 503 P.2d at 40.

mony on medical custom and practice<sup>95</sup> needed to establish the doctor's negligence.<sup>96</sup>

In another recent case,<sup>97</sup> a Louisiana appellate court sharply diverged from the *Canterbury* concept that a patient has the right to control what is done with her body.<sup>98</sup> A woman charged her physicians with malpractice in their performance of a modified radical hysterectomy. She further alleged that she had not consented to as extensive surgery as was performed.<sup>99</sup> The court affirmed the lower court's verdict for the defendants and granted the doctor wide discretion on the basis of the patient's general consent to the operation.<sup>100</sup>

In conclusion, there is still a lack of unanimity on the breadth of a physician's duty to disclose to patients the risks of treatments.<sup>101</sup> While the obvious thrust of *Canterbury* is to limit the prerogative of a physician and to enforce the right of a patient to choose the therapy he will undergo, it remains to be seen whether other courts will adopt its position largely rejecting the requirement of expert testimony and the broad therapeutic privilege. As the fear of malpractice suits against physicians grows and the concern of patients for proper care continues,<sup>102</sup> the need for a clear and practical rule will intensify.

## II

### THE PATIENT'S ABILITY TO GIVE CONSENT

#### THE ELEMENTS OF CONSENT: A CASE STUDY—MENTALLY ILL PATIENTS

As discussed in Part I, many courts within the last year have explored a physician's duty to disclose information and obtain informed consent;<sup>103</sup> none of these cases, however, actually addressed the issue of *who* is capable of giving such consent. Although some of the courts raised the issue of competency to consent by noting Justice Cardozo's words that "[e]very human being of adult years and sound mind has a right to de-

95. *Id.* at \_\_\_, 503 P.2d at 41. See *Negaard v. Estate of Feda*, 152 Mont. 47, 446 P.2d 436 (1968) (using the medical rather than a community standard of care).

96. 160 Mont. at \_\_\_, 503 P.2d at 41.

97. *Bryant v. St. Paul Fire and Marine Ins. Co.*, 272 So. 2d 448 (La. App. 1973).

98. 464 F.2d at 780.

99. 272 So. 2d at 453.

100. *Id.* The court stated that the general consent "included her consent for the surgeon to perform whatever was necessary to remove the potentially dangerous cancerous tissues." *Id.*

101. Cf. Torts, 1966 Ann. Survey Am. L. 209, 232. Under pre-*Canterbury* doctrines, the authors commented on the unsettled law at that time and concluded that only in cases where adverse circumstances were certain (e.g., sterilization) was a burden clearly placed upon a physician to detail the risks to his patient.

102. See National Broadcasting Co. Reports, Hospitals, Doctors, and Patients, transcript of telecast September 22, 1973, available upon written request to the company at 30 Rockefeller Plaza, New York, New York.

103. See, e.g., note 5 *supra*.



termine what shall be done with his own body,"<sup>104</sup> these opinions did not interpret his statement or explain how to apply the criteria he expounded. However, a Michigan circuit court confronted the question directly in *Kaimowitz v. Michigan Department of Mental Health*<sup>105</sup> when it determined whether an adult male, involuntarily confined in a mental hospital, could give legally valid consent to an experimental psychosurgical procedure. This decision, issued at a time when great attention is being focused on the rights of the confined mentally ill,<sup>106</sup> has critical implications for the physician-patient relationship and raises considerable questions as to the practical accuracy of Cardozo's statement.

*Kaimowitz* was decided by the Circuit Court for the County of Wayne, Michigan, on a writ of habeas corpus which charged that a John Doe was being detained illegally for the purpose of experimental psychosurgery.<sup>107</sup> Doe, committed in 1955 under a subsequently repealed Criminal Sexual Psychopathic law,<sup>108</sup> was to serve as the only subject of an experiment conducted by two physicians associated with the Michigan Department of Mental Health and funded by the Michigan legislature.<sup>109</sup> The experiment had sought to compare the effects of psychosurgery on the amygdaloid portion of the limbic system of the brain with the effects of the drug cyproterone acetate on the male hormonal flow, in order to ascertain if either method could control male aggression and thus relieve a patient's suffering from rages.<sup>110</sup> Both John and his parents had signed consent forms<sup>111</sup> which detailed the goals of the operation, the nature of

104. In *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), quoted in *Canterbury*, 464 F.2d at 780, and in *Wilkinson*, 110 R.I. at 295 A.2d at 685, and paraphrased in *Cobbs*, 8 Cal. 3d at 243, 104 Cal. Rptr. at 513, 502 P.2d at 9.

105. *Kaimowitz v. Michigan Dep't of Mental Health*, Civ. No. 73-19434-AW (Mich. Cir. Ct. July 10, 1973), noted in 42 U.S.L.W. 2063 [All subsequent citations shall refer to the slip opinion. Any relevant references appearing in the United States Law Week report shall also be noted.]

106. See, e.g., *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971) appeal pending, No. 72-2634 (5th Cir. 1972) and *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded for clarification of order, 42 U.S.L.W. 3402 (U.S. Jan. 15, 1974) (No. 73-568).

For a general discussion of the rights of mental patients, see B. Ennis & L. Siegel, *Rights of Mental Patients* (1973); B. Ennis, *Prisoners of Psychiatry* (1972).

107. Civ. No. 73-19434-AW, at 1, 42 U.S.L.W. at 2063.

108. See *id.* at 2 n.2. This provision is now codified at Mich. Comp. Laws § 330.356 (Supp. 1973). See note 115 *infra* and accompanying text.

109. Civ. No. 73-19434-AW, at 2-3. Doe was the only subject because the experimenters could not locate any other suitable patients. *Id.* at 3. The criteria for the population were listed in the court's appendix. *Id.* at Appendix, Item 2, at 7.

110. *Id.* at 3. See *id.* at Appendix, Item 1, at 1 for a fuller explanation of the experimental proposal.

111. *Id.* at 4-5. There was some dispute, however, as to whether the parents had agreed to all the procedures or only the initial stages. *Id.* at 5 n.6. In addition, the patient withdrew his consent during the trial. *Id.* at 8 n.9. Nevertheless, the court had held in its first opinion issued on March 15, 1973, that neither Doe's withdrawal of



the procedure, and both the inherent and potential risks. After two specially appointed review committees<sup>112</sup> had approved the treatment on scientific, moral and ethical grounds, the doctors implanted depth electrodes in John Doe's brain as the first stage of the experiment.<sup>113</sup> At this point, plaintiff halted the project by filing suit as a representative of Doe and a public interest group, the "Medical Committee for Human Rights."<sup>114</sup>

A three-judge court, in an opinion issued in March of 1973, declared Doe's detention unconstitutional and later ordered his release.<sup>115</sup> In July of 1973, the same court issued its landmark and unanimous decision that involuntarily detained mental patients are incapable of giving informed, and therefore legally adequate, consent to experimental psychosurgical procedures on the brain.<sup>116</sup>

There were two fundamental but intertwined bases for the latter opinion: the unusually experimental and unpredictable nature of the particular psychosurgical procedure<sup>117</sup> and the involuntary incarceration status of the patient.<sup>118</sup> For the purposes of this case, the court defined psychosurgery<sup>119</sup> narrowly to be that psychosurgery which was highly experimental,<sup>120</sup> was rife with unknown risks<sup>121</sup> and irreversible consequences,<sup>122</sup> and was of only indeterminate benefit to either the patient or

consent, nor his release after a finding that his detention was unconstitutional (see note 115 *infra* and accompanying text) had rendered the issue moot. *Id.* at 7 & n.8. For the text of the consent form, see *id.* at 3-4 n.5.

112. *Id.* at 5. The experimenters' themselves had created the committees, one called the Scientific Review Committee and the other, the Human Rights Review Committee.

113. *Id.*

114. *Id.* The Medical Committee for Human Rights (MCHR) is a national organization of medical students and physicians which focuses its attention upon the rights of patients and the delivery of health care. The case was apparently very well briefed and argued by Dean Frances A. Allen and Prof. Robert A. Eurt of the University of Michigan Law School, both appointed counsel for John Doe. *Id.* at 6, 41.

115. See *id.* at 6. The criminal sexual psychopath statute under which John Doe had been committed had been repealed by the Michigan legislature in 1968. *Id.* at 2 n.2.

116. *Id.* at 31, 42 U.S.L.W. at 2064.

117. See notes 119-23 *infra* and accompanying text.

118. See notes 124, 131, 132, 135, 137 & 138 *infra* and accompanying text. Because of the unusual circumstances facing the Michigan court, it is possible that other courts, confronted with less dramatic modes of treatment, may limit the *Kaimowitz* holding to its facts.

119. Civ. No. 73-19434-AW, at 10, 42 U.S.L.W. at 2063. Other definitions of psychosurgery had been offered to the court and rejected by it. *Id.* at 9-10.

120. *Id.* at 26-27, 42 U.S.L.W. at 2063. Expert testimony established the experimental nature of the procedure. See *id.* at 12, 42 U.S.L.W. at 2063.

121. *Id.* at 11-12, 42 U.S.L.W. at 2063. The court noted the constant interdependence among the areas of the brain. *Id.*

122. *Id.* at 12, 42 U.S.L.W. at 2063. Because of the biological fact that once brain cells are destroyed, they do not regenerate, any physical intervention in the brain has "irreversible" consequences and is by definition a "treatment of last resort." *Id.* Further, psychosurgery that has been done has been associated with a general blunting

society.<sup>123</sup> The court found the circumstances of an involuntarily confined patient relevant because the inherently coercive nature of the institutions which restrict an individual's activities often prompt patients to seek special attention as a source of relief from this debilitating monotony.<sup>124</sup>

In reaching its decision to modify John Doe's ability to consent to these procedures, the court considered elementary tort law. Holding that "informed consent is a requirement of variable demands," the court noted the increased importance of consent in experimental procedures<sup>125</sup> and the heightened need for close scrutiny of the adequacy of that consent.<sup>126</sup> The court outlined the standard elements of informed consent as competency, knowledge, and voluntariness.<sup>127</sup> It then analyzed whether an involuntarily confined mental patient could ever fulfill these criteria.<sup>128</sup>

The court defined "competency" as "the ability of the subject to understand rationally the nature of the procedure, its risks, and other relevant information."<sup>129</sup> Significantly, the court never suggested that either an individual's mental illness<sup>130</sup> or his confinement were dispositive of this issue. Rather, the involuntary detention undermined a patient's capacity to consent to the psychosurgical procedure, and was thus one

of emotions and a reduction in spontaneous behavior, a loss of capacity for learning and an impairment of memory. *Id.* at 17, 42 U.S.L.W. at 2064.

123. *Id.* at 13-17, 42 U.S.L.W. at 2063. There was no definitive evidence that this surgical-medical treatment would ameliorate Doe's problem of violent behavior. *Id.*

124. See *id.* at 29, 33, 42 U.S.L.W. at 2064.

125. *Id.* at 22, 42 U.S.L.W. at 2063-64. The court, citing *J. Katz, Experimentation with Human Beings* 523 (1972), ascribed the following functions to consent: emphasizing the individual's right to choose, encouraging the subject to be an active partner, encouraging the investigator to question his project, and increasing society's awareness of the research. *Civ. No. 73-19434-AW*, at 19-20.

126. In reaching its decision, the court reasoned that its review of the consent given varies with the nature of the treatment contemplated. "When a procedure is experimental, dangerous and intrusive, special safeguards are necessary." *Id.* at 22, 42 U.S.L.W. at 2063-64. Consider the implications for the duty-to-disclose cases, discussed at notes 1-102 and accompanying text. One might ask whether the requirements of a physician's disclosure itself should vary with the procedure involved. See, e.g., *Canterbury*, 464 F.2d at 786-87, mandating that it is the patient's need for the information which governs the duty to disclose.

127. *Civ. No. 73-19434-AW*, at 22, 31, 42 U.S.L.W. at 2064.

128. *Id.* at 22-32, 42 U.S.L.W. at 2064, quoting the ten principles known as the "Nuremberg Code," enumerated in the "Judgment of the Court in United States v. Karl Brandt," *Trial of War Criminals before the Nuremberg Military Tribunal*, Vol. 1 & 2, "The Medical Case," U.S. Gov't Printing Office, Wash., D.C. (1948), reprinted in *Katz, Experimentation with Human Beings* 305 (1972). *Id.* at 23-24. See 289 N. Eng. J. Med. 325 (Aug. 9, 1973) for discussion on the problem of obtaining informed consent in an institutionalized setting.

129. *Id.* at 25, 42 U.S.L.W. at 2064, and citing *Waltz & Scheuneman*, *supra* note 28. See *Canterbury*, 464 F.2d at 787.

130. John Doe reportedly had an I.Q. of at least 80, and it was suggested that he had sufficient mental acuity to comprehend both the treatment and his circumstances. *Civ. No. 73-19434-AW*, at 25.

among several pertinent factors to be considered.<sup>131</sup> The court concluded that the institutional setting here rendered John Doe, as well as a legal guardian, incapable of giving consent to the proposed operation.<sup>132</sup> The court further held that, since it had defined the psychosurgical procedure as highly experimental,<sup>133</sup> satisfaction of the requirement of knowledge of the risks was "literally impossible."<sup>134</sup> Finally, the voluntariness element of informed consent was found to be fundamentally absent due to the patient's long-term and involuntarily detained status.<sup>135</sup>

The court was careful to emphasize in its conclusion that neither the psychosurgery procedure in general nor the coerced confinement for mental health purposes was a complete bar to valid consent. If this psychosurgery ever became an accepted neurosurgical procedure, then "it is possible, with appropriate review mechanisms,<sup>136</sup> that involuntarily detained mental patients could consent to such an operation."<sup>137</sup> Further, the court held that "an involuntarily detained mental patient today can give adequate consent to accepted neurosurgical procedures."<sup>138</sup> Nevertheless, until these conditions were satisfied, the court concluded that the state had an obligation to prevent the experiment's occurrence.<sup>139</sup>

In addition to the common law bases for the holding, the *Kaimowitz* court advanced "compelling constitutional considerations that preclude[d] involuntarily detained mental patients from giving effective consent to this type of surgery."<sup>140</sup> Premising its discussion upon the fact that John Doe was detained at the instance of the state, thereby implicating doctrines of state action,<sup>141</sup> the court held that state authorization of experimental psychosurgery would violate Doe's right to freedom of speech<sup>142</sup> and to privacy.<sup>143</sup> Using innovative analysis, the court determined that

131. This conclusion arguably should provoke closer scrutiny into consent given by any patient who is involuntarily confined and who agrees to treatment procedures.

132. *Id.* at 25-26, 42 U.S.L.W. at 2064. See note 135 *infra*, and text accompanying note 124 *supra*.

133. See text accompanying notes 119-23 *supra*.

134. Civ. No. 73-19434-AW, at 27, 42 U.S.L.W. at 2064.

135. *Id.* at 28, 42 U.S.L.W. at 2064. The court noted that the inequality of authority between mental patients and the physicians clouds any choices by the latter. *Id.* at 29, 42 U.S.L.W. at 2064. This fact raises doubts about conclusions that other institutionalized patients can give voluntary and knowledgeable consent to less dramatic treatments. *Id.* at 21, 42 U.S.L.W. at 2064. See note 131 *supra*.

136. See notes 125 & 126 *supra* and accompanying text.

137. *Id.* at 40.

138. *Id.*

139. This is an interesting posture for the court to take. While arguably an admirable decision under the facts of this case, there is a potential for abuse since, under the guise of paternalism, the state limits the options of an institutionalized person.

140. *Id.* at 32.

141. *Id.*, 42 U.S.L.W. at 2064.

142. *Id.*, 42 U.S.L.W. at 2064.

143. *Id.* at 36, 42 U.S.L.W. at 2064.

the first amendment protections extended to the generation of ideas.<sup>144</sup> In comparison to psychosurgery's potential to irreparably injure an individual's mental processes, the state was unable to demonstrate any sufficiently compelling interests to warrant overriding the patient's first amendment guarantees. Similarly, an individual's mind was also protected under the Supreme Court's elusively defined right to privacy.<sup>145</sup> The compelling state interest test was applied, and again the state's interest was held inadequate to justify the intrusive medical procedure.<sup>146</sup>

While the logic of the *Kaimowitz* theory is enticing, that in order to enjoy an "effective" freedom to speak one must be able to think, it relies upon debatable constitutional foundations.<sup>147</sup> First of all, the United States Supreme Court has not delineated what it considers "effective" speech. No cases have actually mandated that there is any right to attain a certain level of competence or that individuals possess uniform abilities to exercise first amendment freedoms.<sup>148</sup> Second, the *Kaimowitz* court found no cases in point and was therefore forced to rely upon general statements by legal scholars and dicta in several earlier Supreme Court decisions.<sup>149</sup> The most probative precedent cited by the Michigan court was *Stanley v. Georgia*,<sup>150</sup> a case in which the Supreme Court implicitly recognized and protected the interrelationship among the human mind, the right of expression, and the right to privacy.<sup>151</sup> The *Kaimowitz* reasoning was

144. *Id.* at 35, 42 U.S.L.W. at 2064. The court relied upon *Stanley v. Georgia*, 394 U.S. 557 (1969); *Whitney v. California*, 274 U.S. 357 (1927); *Abrams v. United States*, 250 U.S. 616 (1919); B. Cardozo, *The Paradoxes of Legal Science*, Selected Writings of Benjamin Nathan Cardozo 317-18 (1947); Emerson, *Toward a General Theory of the First Amendment*, 72 Yale L.J. 877 (1963). Unfortunately the facts of *Stanley* (the situs of the acts in question and the transitory nature of the activity (reading)) render the case easily distinguishable from *Kaimowitz*; however, given the unique nature of the *Kaimowitz* litigation, the court was forced to reason by analogy.

145. *Id.* at 36, 42 U.S.L.W. at 2064. The court reasoned that constitutional protection of one's mind is at least as deserving as other already recognized ideals. See *Roe v. Wade*, 410 U.S. 113 (1973) (one's body); and *Stanley v. Georgia*, 394 U.S. 557 (1969) (one's home); *Griswold v. Connecticut*, 381 U.S. 479 (1962) (marital bed).

146. Civ. No. 73-19434-AW, at 39, 42 U.S.L.W. at 2064.

147. See note 144 *supra*.

148. Cf. *San Antonio School District v. Rodriguez*, 411 U.S. 1 (1973), where the court rejected the appellants' equal protection argument that equal educational opportunities were necessary to an informed and intelligent exercise of first amendment freedoms by stating that there is no "guarantee to the citizenry of the most effective speech." *Id.* at 35-36. In any case, it would always have to be recognized that discrepancies will exist among individuals' innate capabilities. In addition, there are many circumstances in which the Court has justified limitations on individuals' right to exercise certain of their first amendment rights at all. See, e.g., *United States Civil Service Comm'n v. National Ass'n of Letter Carriers*, 93 S. Ct. 2880 (1973).

149. See, e.g., cases cited in notes 144 & 145 *supra*.

150. 39 U.S. 557 (1969) (conviction for possession of obscene matter in private held unconstitutional).

151. *Id.* at 564-66. The first amendment permits a person to "satisfy his intellectual and emotional needs in the privacy of his own home" and prohibits the government from exercising control over people's minds and private thoughts. *Id.* at 565.



also founded upon the preferred constitutional position of the first amendment, upon the highly personal and thereby potentially fundamental nature of the rights involved, and upon the very unusual fact situation presented.<sup>152</sup> It is disappointing, however, that the court did not fully explore the implications of its constitutional premises nor detail the controversial issues over which it glided.

In summary, the *Kaimowitz* court did not conclude that involuntarily detained mental patients categorically lack the capacity to give informed consent, but rather it recognized that there are procedures for which the state could not allow such patients to give consent.<sup>153</sup> The person who is involuntarily institutionalized is specially situated by the state, which must then afford him or her additional protections. One must note, however, that ostensible protections can function as disabilities and that the result reached by the court means that the ambit of free choice with respect to personal health decisions<sup>154</sup> is further restricted for this class of people.

Even before *Kaimowitz*, other courts had considered the ability of mental patients to give consent to a proposed treatment. In *New York City Health and Hospitals Corp. v. Stein*,<sup>155</sup> a city hospital had voluntarily applied for court authorization<sup>156</sup> to give electroshock treatments to an adult female patient, diagnosed as schizophrenic and involuntarily retained,<sup>157</sup> who had refused to consent to the therapy. The hospital sought to dispense with the patient's consent "on the ground that she is incompetent to make a reasoned decision."<sup>158</sup> The court rejected the hospital's petition, reasoning that since the patient would suffer the consequences of an erroneous decision, her refusal should be determinative unless she lacked the mental capacity to "knowingly consent or withhold her consent."<sup>159</sup> With this presumption of competency, the court cautiously considered the conflicting testimony of the psychiatric witnesses for both parties. Ordering further retention of the patient, the judge nevertheless held that she did have the mental capacity to refuse treatment.<sup>160</sup>

152. This is apparently the only reported case dealing with the problems involved in psychosurgery. American Civil Liberties Union Newsletter (1973).

153. See note 135 *supra* and accompanying text.

154. See *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), and cited by *Kaimowitz*, Civ. No. 73-19434-AW, at 18.

155. 70 Misc. 2d 944, 335 N.Y.S.2d 461 (Sup. Ct. 1972).

156. *Id.* at 944-45, 335 N.Y.S.2d at 463. The hospital had applied under a statute which was not to take effect until the following January. See N.Y. Mental Hygiene Law § 15.03(b) (McKinney Supp. 1973).

157. See N.Y. Laws [1964], ch. 738, § 5, as amended, N.Y. Mental Hygiene Law §§ 31.27 & 31.29 (McKinney Supp. 1973).

158. 70 Misc. 2d at 945, 335 N.Y.S.2d at 463.

159. *Id.* at 946, 335 N.Y.S.2d at 464.

160. *Id.* at 946-47, 335 N.Y.S.2d at 465.



Both *Stein* and *Kaimowitz* lend support to the proposition that hospitalized mental patients should not be presumed "incompetent" solely as a result of their mental disability or their confinement. These decisions each suggest that, as with any other patients, physicians have a duty to disclose information to the mentally ill and must obtain their informed consent before instituting therapy.<sup>161</sup> Unfortunately, neither of these cases addressed the problem of defining what characteristics or what standard of proof are required to render an adult incompetent to determine his medical treatment. Further, jurisdictions vary greatly on the capacities they ascribe to the mentally ill. Some states, such as New Jersey<sup>162</sup> and New York,<sup>163</sup> provide by statute that hospitalization is not presumptive of incompetency to exercise civil rights. Case law in New York upholds the involuntarily detained's right to choose his hospital status<sup>164</sup> and to refuse treatment.<sup>165</sup> In Wisconsin, however, involuntary confinement in a mental institution raises a statutory rebuttable presumption of incompetency.<sup>166</sup>

Legal procedures for evaluating incompetency to make personal health decisions vary considerably. Where involuntary confinement is evidence of incapacity, the commitment proceeding has been used as the forum for the adjudication of an adult as incompetent to make medical decisions;<sup>167</sup> but where detention by the state is not presumptive of in-

161. See "right to informed consent" cases cited at note 3 *supra*. See, e.g., *Kaimowitz*, Civ. No. 73-19434-AW, at 18 & n.18, 19-21, 42 U.S.L.W. at 2064. For a similar conclusion on the more limited issue of the right to refuse hospitalization for mental illness, see *Lessard v. Schmidt*, 349 F. Supp. 1078, 1094 (E.D. Wis. 1972), vacated and remanded for clarification of order, 42 U.S.L.W. 3402 (U.S. Jan. 15, 1974) (No. 73-568) (holding unconstitutional Wisconsin's procedures for civil commitment of the mentally ill).

162. See N.J. Stat. Ann. § 30:4-24.2 (Supp. 1975). This section, entitled "Rights of Patients," was applied in *Bush v. Kallen*, 123 N.J. Super. 175, 302 A.2d 142 (1973) (patients' attorneys have authority to inspect their clients' medical records if patients consent, in spite of patients' involuntary institutionalization).

163. N.Y. Mental Hygiene Law § 29.03 (McKinney Supp. 1975). See also N.Y. Mental Hygiene Law § 15.01 (McKinney Supp. 1975) which provides that "no person shall be deprived of any civil rights . . . solely by reason of receipt of services for a mental disability."

164. See *In re Buttenow*, 23 N.Y.2d 385, 244 N.E.2d 677, 297 N.Y.S.2d 97 (1968), discussed at notes 171-77 *infra* and accompanying text. See also *In re Curry*, 470 F.2d 368, 372 n.8 (D.C. Cir. 1973).

165. See *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971), reversing a summary judgment in defendants' favor on the ground that a hospital's psychiatric staff violated the first amendment by forcibly administering medication over the patient's protests based upon Christian Scientist beliefs. In its opinion, the court reaffirmed the general principle that "[a]bsent a specific finding of incompetence, the mental patient retains his right to sue or defend in his own name, to sell or dispose of his property, to marry, to draft a will, and, in general to manage his own affairs." *Id.* at 68.

166. Wis. Stat. Ann. § 51.005(2) (1951). See *Lessard v. Schmidt*, 349 F. Supp. 1078, 1088-89 (E.D. Wis. 1972), vacated and remanded for clarification of order, 42 U.S.L.W. 3402 (U.S. Jan. 15, 1974) (No. 73-568), enumerating other disabilities imposed by statute upon those adjudged mentally ill in Wisconsin.

167. See *Lessard v. Schmidt*, 349 F. Supp. 1078, 1088 (E.D. Wis. 1972), vacated and remanded for clarification of order, 42 U.S.L.W. 3402 (U.S. Jan. 15, 1974) (No. 73-568).

capacity,<sup>168</sup> no legal procedure exists to find a person incompetent to consent to medical treatment. The general civil incompetency hearing is usually inadequate for medical competency purposes because most state statutes focus solely upon the ability of an individual to manage his financial and proprietary affairs,<sup>169</sup> a standard distinct from the evidence relevant to competency to understand one's medical problems.

A second unresolved issue is the scope of authority of a court-appointed guardian, without specific court authorization, to make health care decisions for an adjudicated incompetent.<sup>170</sup> In the leading New York case, *In re Battenow*,<sup>171</sup> the Court of Appeals of New York permitted an adjudicated incompetent—and not her committee<sup>172</sup>—to decide her hospitalization status.<sup>173</sup> Her committee had protested the plaintiff's choice to become a voluntarily hospitalized patient because the voluntary status lacked the procedural safeguards given to the involuntary status.<sup>174</sup> Judge Fuld first liberally construed the former New York Mental Hygiene Law<sup>175</sup> to render it constitutional, holding that there were the same safeguards for both categories.<sup>176</sup> He then concluded that "an adjudication of incompetency is in no way a decision or judgment that the person so adjudicated may not act in matters involving his personal status."<sup>177</sup>

As the foregoing discussion demonstrates, courts have not yet articulated the criteria which should govern the determination that an adult is incapable of making health care decisions.<sup>178</sup> Because courts are now

168. The fact of a patient's detention should not be used to determine capacity since involuntary confinement statutes present standards to determine the need for hospitalized care and treatment, factors which may be unrelated to a patient's general ability to consent to treatment. See, e.g., N.Y. Mental Hygiene Law § 35.01 (McKinney Supp. 1973).

169. E.g., N.Y. Mental Hygiene Law § 78.01 (McKinney Supp. 1973). Cf. note 168 supra.

170. E.g., *Strunk v. Strunk*, 455 S.W.2d 145 (Ky. 1969). See notes 190-334 infra and accompanying text for a discussion of the authority of a parent or the state to consent to treatments for a child.

171. 23 N.Y.2d 385, 244 N.E.2d 677, 297 N.Y.S.2d 97 (1968), rev'g 29 App. Div. 2d 338, 285 N.Y.S.2d 223 (2d Dep't 1967).

172. New York courts are empowered to appoint a committee which acts under judicial supervision to maintain the incompetent's property and other affairs. See N.Y. Mental Hygiene Law § 78.01 et seq. (McKinney 1972).

173. 23 N.Y.2d at 388, 244 N.E.2d 678, 297 N.Y.S.2d 99. The patient had switched herself from an "involuntarily" hospitalized status to a "voluntary" patient. Id.

174. Id.

175. N.Y. Laws [1927], ch. 426, § 7, as amended, N.Y. Mental Hygiene Law §§ 31.13-31.25 (McKinney Supp. 1973).

176. 23 N.Y.2d at 393, 244 N.E.2d at 681, 297 N.Y.S.2d at 103.

177. Id. at 394, 244 N.E.2d at 682, 297 N.Y.S.2d at 104.

178. See *Matter of Long Island Jewish-Hillside Medical Center*, 73 Misc. 2d 395, 2 N.Y.S.2d 356 (Sup. Ct. 1973), where the court had to determine if a hospital could operate on a severely debilitated elderly patient who had intermittently opposed the procedure. The court held he was unable to make health judgments, but its reasoning is unclear. The only "rule" to be drawn from the case is that aged adults with

confronted with the issue of an adult's ability to decide health care matters,<sup>179</sup> the author suggests that courts would benefit from the consistent application of the following test, derived from the decisions in *Canterbury v. Spence*,<sup>180</sup> *Kaimowitz v. Michigan Department of Mental Health*,<sup>181</sup> and *New York Health and Hospitals Corp. v. Stein*.<sup>182</sup> An individual should be considered competent to consent to or refuse treatment if he can understand the information which a physician is under a legal duty to impart to him concerning the risks, benefits, and alternatives to a proposed treatment. Moreover, a rebuttable presumption of competence should be utilized in every case. Expert testimony should be admissible to explain the condition of the patient, the nature of the proposed therapy, and the magnitude of risks involved, but such testimony should not be conclusive on the competency issue, since the decision to undergo treatment is a non-medical judgment.<sup>183</sup> Relevant topics of inquiry on the question of competency should include the patient's intelligence,<sup>184</sup> emotional state, ability to handle personal affairs, and the reasons proffered for acceptance or refusal of treatment. Furthermore, as *Kaimowitz* demonstrates, certain circumstances (such as lengthy institutionalization) may diminish an individual's capacity and thus necessitate inquiry into a patient's history. Determinations of incompetency as to health matters should be based upon a preponderance of the evidence that the patient is incapable of comprehending the information given to him by his physician. A court should be able to impose its own judgment of what is best for the patient only when the patient has been expressly adjudicated incapable of making his or her own health care decisions.<sup>185</sup> Where a court finally concludes that an individual is incompetent to consent to or refuse treatment, the court should either make the medical decision itself, on the basis of the evidence it needs to ascertain incapacity, or should delegate the authority to a guardian<sup>186</sup> acting under close judicial supervision. As *Kaimowitz* indicated, the kind of consent required varies with the procedure to be undertaken.<sup>187</sup> Where surgical, major medical,

arteriosclerosis who voluntarily enter hospitals, who need life saving operations and who do not vehemently oppose such operations at all times, may be deemed incompetent to refuse treatment.

179. See HEW Report, *supra* note 84, at 3.

180. 464 F.2d 772 (D.C. Cir. 1972).

181. Civ. No. 73-19434-AW (Mich. Cir. Ct. July 10, 1973), 42 U.S.L.W. 2063.

182. 70 Misc. 2d 944, 335 N.Y.S.2d 461 (Sup. Ct. 1972).

183. See, e.g., *Canterbury*, 464 F.2d at 785.

184. Cf. *Kaimowitz*, Civ. No. 73-19434-AW, at 25.

185. See Harper & James, note 53 *supra*.

186. Cf. *In re Bittenow*, 23 N.Y.2d 386, 244 N.E.2d 677, 297 N.Y.S.2d 97 (1968), discussed at notes 171-77 *supra* and accompanying text. The choice of guardians is thus crucial; courts should select individuals on the basis of their demonstrated intent and ability to protect the rights and interests of the patient.

187. *Kaimowitz*, Civ. No. 73-19434-AW, at 22. See note 126 *supra*.

electroshock, radiation, or experimental treatments are proposed, only the court should have the power to authorize the treatment.<sup>188</sup> Finally, a finding of incapacity to consent to or refuse treatment should not be considered presumptive of general civil incapacity, mental illness, or the need for involuntary care.<sup>189</sup> Each of these issues is a distinct question which should be adjudicated by careful consideration of its own applicable standards.

#### MINORS' CAPACITY TO CONSENT TO HEALTH CARE

*Introduction.*—In most states, unless an "emergency" existed or the child was emancipated, physicians traditionally had a legal obligation to obtain the consent of the parents or the person standing *in loco parentis* before examining or treating a minor.<sup>190</sup> Minors' own capacity to consent, however, has been recognized for certain medical procedures,<sup>191</sup> as restrictive state laws requiring parental consent<sup>192</sup> have been abrogated and the scope of emergency situations has been broadened by legislatures.<sup>193</sup> Distinct similarities exist between the provisions of some "medical consent" statutes<sup>194</sup> and the common law rule of emancipation,<sup>195</sup>

188. See, e.g., N.Y. Mental Hygiene Law § 15.03(B)(4) (McKinney Supp. 1973). See N.Y. Dep't Mental Hygiene, Draft Regulations, Part 27, Quality of Care and Treatment, § 27.2 (1973).

189. Cf. notes 168 & 169 *supra* and accompanying text.

190. The reason for this is that physicians and hospitals fear liability for battery. See Stern, Medical Treatment and the Teenager: The Need for Parental Consent, 7 Clearinghouse Rev. 1 (May 1973) [hereinafter cited as Clearinghouse]. For a thorough discussion of this topic see Pilpel, Minors' Rights to Medical Care, 36 Albany L. Rev. 462 (1972). But see Comment, Medical Care and the Independent Minor, 10 Santa Clara Law. 334 n.3 (Spring 1970), for a collection of cases demonstrating the courts' confusion regarding the necessity for parental consent. One commentator stated that she had

found no reported cases holding a physician civilly liable for furnishing medical services without parental consent where the minor was over the age of 15 and the treatment was rendered with the minor's consent and was for the minor's benefit.

Zuckerman, Abortion and the Constitutional Rights of Minors, A.C.L.U. Reports 4 n.2 (July 1973).

191. Medical procedures usually excepted include diagnosis and treatment of venereal diseases (see, e.g., Alaska Stat. § 09.65.100(a) (1972); Ariz. Rev. Stat. Ann. § 44-132.01 (Supp. 1973)), donation of blood (see, e.g., Iowa Code Ann. § 599.6 (Supp. 1973) (18 years or older)), and treatment of drug related problems (see Clearinghouse, *supra* note 190, at 2 n.9 for collection of statutes permitting treatment of minors for addiction and related problems).

192. The requirement of parental consent may be imposed implicitly or explicitly, but often is mandated by means of statutes defining the age of majority. Clearinghouse, *supra* note 190, at 1 n.2. See, e.g., Wis. Stat. § 990.01(20) (Cum. Supp. 1973) (age of majority is 18 years old); Wyo. Stat. Ann. § 14-1.1 (Supp. 1973) (age of majority is 19).

193. See, e.g., Fla. Stat. Ann. § 458.21 (Supp. 1973); Ill. Ann. Stat. ch. 91, § 18.3 (Smith-Hurd 1973); Pa. Stat. Ann. tit. 35, § 10104 (Supp. 1973).

194. See, e.g., N.Y. Pub. Health Law § 2504(1) (McKinney Supp. 1973) ("Any person who is eighteen years of age or older, or is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services for himself

each including such indices as marriage, judicial decree, act of parent or enlistment in the military service.<sup>196</sup> In a growing number of states, courts have gone even further and gradually have transformed the rule of the "emancipated minor" into the rule of the "mature minor"<sup>197</sup> by refusing in many situations to rigidly apply these technical requirements for emancipation.<sup>198</sup> Certain statutes provide that a minor will be deemed "mature" and able to give valid consent to medical treatment where the procedure is for the benefit of the minor and he can understand its nature and consequences.<sup>199</sup> Although commentators have applauded such legislative innovations, they note that the difficulty in determining the "legal maturity" of minor patients and the inability of physicians to hold them liable for their debts may serve as continuing impediments to the flow of medical services to minors.<sup>200</sup>

Beyond the inherent difficulties involved in construing "medical consent" statutes, other problems arise from the widespread failure of courts and legislatures to delineate adequately either the scope of minors' rights or the theory upon which the state intervenes on their behalf.<sup>201</sup>

or herself, and the consent of no other person shall be necessary."); Colo. Rev. Stat. Ann. § 41-2-13 (Supp. 1971).

195. See, e.g., *Lawson v. Brown*, 349 F. Supp. 203 (W.D. Va. 1972). The concept of emancipation applies in other contexts beyond consent to medical treatment and is generally delineated by case law in each state. See, e.g., 67 C.J.S. Parent and Child § 86 (1950) and 32 A.L.R.3d 1055 (1970).

196. Some statutes explicitly provide that emancipated minors may consent effectively to medical treatment. See, e.g., Ind. Ann. Stat. § 35-4409 (1969). Other statutes provide that certain circumstances (considerations derived from the case law concerning emancipation) render a minor competent to consent: marriage or marriage and divorce (see, e.g., Ala. Code tit. 34, § 76 (Cum. Supp. 1971); Cal. Civ. Code § 25.6 (West Supp. 1973)); pregnancy or parenthood (see, e.g., Ill. Ann. Stat. ch. 91, § 18.1 (Smith-Hurd 1973); Md. Ann. Code art. 43, § 135 (Supp. 1973)); active duty in the military (see, e.g., Cal. Civ. Code § 25.7 (West Supp. 1973)).

197. See Pilpel & Wechsler, *Birth Control, Teenagers and the Law*, 1 Family Planning Perspective 29, 30 (Spring 1969); Pilpel & Zuckerman, *Abortion and the Rights of Minors*, 23 Case W. Res. L. Rev. 779, 782 (1972).

198. See, e.g., *Schumm v. Schumm*, 122 N.J. Super. 146, 299 A.2d 423 (Super. Ct. Ch. 1973); *Lacey v. Laird*, 166 Ohio St. 12, 139 N.E.2d 25 (1956).

199. See, e.g., Miss. Code Ann. § 41-41-3 (1972): "Any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment" may effectively consent.

200. See Clearinghouse, *supra* note 190, at 4; *Medical Care and the Independent Minor*, *supra* note 190, at 344-45.

201. See, e.g., *Matter of Comm'r of Social Serv. on behalf of Michael D. v. Bette D.*, 72 Misc. 2d 428, 339 N.Y.S.2d 89 (Family Ct. 1972) which raises but never answers this question:

Is the consent to surgery by a parent or other person standing *in loco parentis* to the child necessary only because the child, by virtue of his infancy lacks the capacity to consent or is consent necessary because the parent has a property interest in the body of his child?

*Id.* at 430, 339 N.Y.S.2d at 91. The concept of a "proprietary" interest in children is highlighted in cases where parents consent to surgical invasion of one child's body for the purpose of donating an internal organ to another person. This topic, however, is beyond the scope of this article. See 35 A.L.R.3d 692 (1971); Curran, *A Problem*



When the issue of a minor's need for health services emerges and no statutory provision infuses the child with decision-making power, courts must adjudicate complex questions regarding the priority of authority to consent to or refuse treatment. Conflicts have surfaced in litigation in two basic forms. One recent group of cases raises the issue of the state's role as arbiter when disagreements between a parent and a child arise over the advisability of the child's abortion. There is also another category of actions wherein the courts have sought to define the state's role vis à vis the parents as the guardian of the child's best interests when non-emergency medical treatments have been recommended.

*Authority to Consent—When Parent and Child Disagree.*—Abortion cases have provided a vehicle for examination of broad medical consent statutes which have been construed to allow female minors to obtain and refuse this medical treatment in derogation of parental wishes. Aside from local statutory decisions,<sup>202</sup> certain cases have arisen as a result of unanswered questions contained in United States Supreme Court rulings. In particular, *Roe v. Wade*<sup>203</sup> signalled the possibility of a constitutional right to abortion,<sup>204</sup> and now has necessitated analysis of the constitutional effect of the incidents of minority.<sup>205</sup>

While it is difficult to determine whether the opinions highlighted below are indicative of judicial (particularly trial court) tendencies with respect to the general issue of minors' capacity to consent to health care,<sup>206</sup> these cases are significant because very few parent-child disputes reach the adjudicative stages. The cases examined suggest that one approach to facilitate courts' determination of the minor's ability to understand the proceedings and to give an informed consent is a "totality of circumstances" test.<sup>207</sup> Certain other cases evidence judicial interpretation of the Supreme Court decisions leading to the conclusion that the abortion decision rests solely with the pregnant minor herself.<sup>208</sup>

of Consent: Kidney Transplantation in Minors, 34 N.Y.U.L. Rev. 891 (1959). See also N.Y. Times, Aug. 31, 1973, at 14, col. 2, which relates an incident in which parents consented to the removal of life-sustaining breathing tubes from their injured son so that his kidney could be removed and prepared for transplanting; and N.Y. Times, Oct. 28, 1973, at 3, col. 4, reporting a state appeals court ruling that a Louisiana law which prevents a minor from donating private property had stopped a retarded teenager from giving one of his kidneys to an ailing sister despite parental consent.

202. See *Ballard v. Anderson*, 4 Cal. 3d 873, 484 P.2d 1345, 95 Cal. Rptr. 1 (1971); *In re Smith*, 16 Md. App. 209, 295 A.2d 238 (1972).

203. 410 U.S. 113 (1973).

204. See note 6 *supra*.

205. See *Coe v. Gerstein*, Civ. No. 72-1842 (S.D. Fla. Aug. 13, 1973), discussed at notes 257-70 *infra* and accompanying text.

206. The difficulty actually stems from the inevitably controversial and unique nature of the abortion decision.

207. See *Matter of P.J.*, 12 Cr. L. Rptr. 2549 (D.C. Super. Ct. Feb. 6, 1973), discussed at notes 247-49 *infra* and accompanying text. See also *People v. Lara*, 67 Cal. 2d 365, 432 P.2d 202, 62 Cal. Rptr. 586 (1967), and cases cited at note 250 *infra*.

208. See *Coe v. Gerstein*, Civ. No. 72-1842 (S.D. Fla. Aug. 13, 1973).

Some states have elected to deal with this consent problem statutorily. At least fourteen states now provide that minors may consent to medical and surgical treatment related to pregnancy.<sup>209</sup> Two of these states, however, Hawaii and Missouri, specifically exclude abortion as a type of "pregnancy-related treatment" covered by their statutes.<sup>210</sup> Virginia has specific provisions in its therapeutic abortion statute requiring parental consent for unmarried minors and spousal approval for married minors.<sup>211</sup>

Although eleven states have left for judicial determination the question of whether pregnancy-related treatment includes abortion, only California and Maryland have resolved the issue.<sup>212</sup> In the 1971 case *Ballard v. Anderson*,<sup>213</sup> the California courts reviewed the refusal of a therapeutic abortion committee to consider the application of a twenty year-old, unmarried, indigent minor living at home, for the sole reason that she had not obtained parental consent. The Supreme Court of California vacated the decision of the court of appeals and specifically held that the California medical treatment statute<sup>214</sup> emancipated unmarried, pregnant minors for the purpose of obtaining therapeutic abortions without parental consent.<sup>215</sup> In so holding, the court essentially interpreted a consent statute, passed fourteen years before California's therapeutic abortion act, as giving minors the power to consent to a broader class of medical procedures than was legally permissible at the time of that statute's enactment. Since *Ballard*, the United States Supreme Court's

209. Ala. Code tit. 22, §§ 104(15) to 104(22) (Supp. 1971); Cal. Civ. Code § 34.5 (West 1954); Del. Code Ann. tit. 13, § 708 (Supp. 1970); Ga. Code Ann. § 88-2904 (Supp. 1972); Hawaii Rev. Stat. §§ 577A-1 to 577A-2 (Supp. 1972); Kan. Stat. Ann. § 58-123 (Supp. 1972); Ky. Rev. Stat. Ann. § 214.185 (Supp. 1972); Md. Ann. Code art. 43, § 135 (Supp. 1973); Minn. Stat. Ann. § 144.343 (Supp. 1973); Miss. Code Ann. § 41-41-3 (1972); Mo. Stat. Ann. §§ 431.061 to 431.063 (Supp. 1973); N.J. Stat. Ann. § 9:17A-1 (Supp. 1973); Pa. Stat. Ann. tit. 35, § 10103 (Supp. 1973); Va. Code Ann. § 32-137 (Supp. 1973). For a comprehensive table of state legislation relating to treatment of minors as of September, 1971, see Pilpel, *Minors' Rights to Medical Care*, 36 Albany L. Rev. 462, 472 (1972).

210. Hawaii Rev. Stat. § 577A-1 (Supp. 1972); Mo. Stat. Ann. § 431.061(1) (Supp. 1973).

211. Va. Code Ann. § 18.1-62.1(e) (Supp. 1973) (parental consent required for women under 18 and for any woman deemed an infant or incompetent by a court of competent jurisdiction). The validity of this provision may be in doubt, however. See *Coe v. Gerstein*, Civ. No. 72-1842 (S.D. Fla. Aug. 13, 1973) (discussed at notes 257-70 *infra* and accompanying text) striking down a similar Florida statute.

212. See notes 213-16 *infra* (California) and 218-34 *infra* (Maryland) and accompanying text.

213. 4 Cal. 3d 873, 484 P.2d 1345, 95 Cal. Rptr. 1 (1971).

214. Cal. Civ. Code § 34.5 (West 1954), which provides in pertinent part: Notwithstanding any other provision of the law, an unmarried pregnant minor may give consent to the furnishing of hospital, medical and surgical care related to her pregnancy, and such consent shall not be subject to disaffirmance because of minority.

215. 4 Cal. 3d at 884, 484 P.2d at 1353, 95 Cal. Rptr. at 9.

decision in *Roe v. Wade*<sup>216</sup> has expanded the class of legal abortions even further by validating only those state regulations designed to protect either the fetus at the point of viability or maternal health at the end of the first trimester.<sup>217</sup> In view of the *Ballard* court's reasoning that minors possess discretion which encompasses the right to obtain a legal abortion, *Roe v. Wade* may well have enlarged the dimensions of minority emancipation in California.

In 1972, the Maryland Court of Special Appeals went one step beyond *Ballard* when it interpreted Maryland's minority consent statute in *In re Smith*.<sup>218</sup> Cindy Lou Smith, sixteen years of age, unmarried, unemancipated and two months pregnant, appealed a juvenile court order which had been issued pursuant to her mother's petition and which had directed her to submit to medical procedures possibly leading to an abortion.<sup>219</sup> Affirming that Cindy was a "child in need of supervision,"<sup>220</sup> the appellate court nevertheless reversed the lower court's order requiring the examinations related to her pregnancy.<sup>221</sup>

Since the status of unemancipated minors was governed generally by common law doctrine which dictated that legally enforceable actions required parental consent, any contrary principles granting minors new rights and independence needed to be expressly provided by statute.<sup>222</sup> In *Smith*, however, the real question facing the court was not the necessity of parental consent, but rather the ability of a minor to act in derogation of her parent's will.<sup>223</sup>

Acknowledging that the right to abortions was purely statutory,<sup>224</sup>

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216. 410 U.S. 113 (1973).

217. *Id.* at 163-64.

218. 16 Md. App. 209, 215, 295 A.2d 238, 241 (1972).

219. The state's statute permits abortions only under specified conditions, so the court merely had the power to order Cindy to be examined to see if she qualified for the treatment. See note 224 *infra*.

220. *Id.* at 215, 295 A.2d at 241.

221. *Id.* at 226, 295 A.2d at 246.

222. See Md. Ann. Code art. 43, § 135(a) (Supp. 1973), which provides:

(a) A minor shall have the same capacity to consent to medical treatment as an adult if one or more of the following apply: (1) The minor has attained the age of eighteen (18) years. (2) The minor is married or the parent of a child. (3) The minor seeks treatment or advice concerning venereal disease, "pregnancy" or contraception not amounting to sterilization. (4) In the judgment of a physician treating a minor, the obtaining of consent of any other person would result in such delay of treatment as would adversely affect the life or health of the minor. (5) The minor seeks treatment or advice concerning any form of drug abuse as defined in § 2(d) of Article 43B of the Annotated Code . . . (Emphasis added.)

223. 16 Md. App. at \_\_\_, 295 A.2d at 245.

224. See *Id.* at \_\_\_, 295 A.2d at 244-45. This case was decided before *Roe v. Wade*. See Md. Ann. Code art. 43, §§ 137 to 139 (1971), which enumerate the limited circumstances under which an abortion is available. In fact, it was unclear whether Cindy even could have legitimately obtained an abortion. 16 Md. App. at \_\_\_, 295 A.2d at 246.

the court reviewed the Maryland Code abortion provisions, Article 43, sections 137 to 139, which provided in particular in section 138 that no person could be forced to submit to an abortion.<sup>225</sup> By defining the phrase "treatment . . . concerning . . . pregnancy" in Maryland's minors' consent statute<sup>226</sup> to include abortions, the court granted minors the authority of adults for these purposes. This theory thus placed minors within the category of "person(s)" described in section 138 of the abortion statute.<sup>227</sup> The court's finding that the legislative intent was to permit minors to override their parents' wishes has been the subject of some comment.<sup>228</sup> If the philosophy behind the enactment had been "to encourage children not to have unplanned families," as the lower court had indicated,<sup>229</sup> Cindy's capacity to oppose her parents would not have been within legislative contemplation. Thus the court could have decided that the order for an abortion examination would have been appropriate. The appellate court, however, held that the legislature's design was to emancipate the minor with respect to any medical care encompassed by the statute as construed by the court, and therefore Cindy's decision was correctly controlling.<sup>230</sup>

Illustrative of the theoretical difficulties in these cases are the contrasting approaches to the problem adopted by the *Smith* trial and appellate courts, which each addressed itself to different fundamental issues. The lower court emphasized the practical hardships which would face Cindy, her parents and the unborn child.<sup>231</sup> The appellate court instead concerned itself with the issue of who should have the power to consent to, or refuse, the medical treatment.<sup>232</sup> While this Maryland decision may augur well for the rights of minors to consent to abortions in the other nine states similarly situated,<sup>233</sup> such a forecast may be a little optimistic because the Maryland statute<sup>234</sup> is exemplary in its extension of minors' rights.

225. Md. Ann. Code art. 43, §§ 138(a) and 138(c) (1971).

226. Md. Ann. Code art. 43, § 135(a)(3) (Supp. 1973). See note 222 supra.

227. 16 Md. App. at 225, 295 A.2d at 246. See note 225 supra and accompanying text.

228. See 7 Suffolk U.L. Rev. 1157, 1162-63 (1973).

229. 16 Md. App. at 217, 295 A.2d at 242.

230. Id. at 225, 295 A.2d at 246.

231. Id. at \_\_\_, 295 A.2d at 244. The trial judge noted the hardship a baby was likely to impose on a social agency or the grandparents since the young parents were bound to have financial and other problems.

232. See id. at \_\_\_, 295 A.2d at 245-46. For recently promulgated federal guidelines dealing with sterilization procedures for persons under 21 and legally incapable of consenting, see Proposed H.E.W. Reg. § 50.901-905, 38 Fed. Reg. 26460 (Sept. 21, 1973).

233. See notes 209-12 supra and accompanying text.

234. Md. Ann. Code art. 43, § 135(a) (Supp. 1973). See also American Academy of Pediatrics, Committee on Youth, A Model Act Providing for Consent of Minors for Health Services, 24 Juvenile Justice 60 (1973).

*Smith* and *Ballard* thus demonstrate a technique in statutory construction. To protect minors' ability to control the procedures to which their bodies would be subject, these courts construed the provisions relating to pregnancy in the relevant medical consent statutes as authorizing female minors to consent to their own abortions. In each of these cases, the scope of this authority was governed by the parameters of legal abortions as set out in the corresponding state therapeutic abortion statute. This technique now may be employed on a broader scale since the Supreme Court's decisions in *Roe v. Wade*<sup>235</sup> and *Doe v. Bolton*<sup>236</sup> constitute a nation-wide and constitutionally-founded expansion of the category of legal abortions.<sup>237</sup> At the very least, the *Ballard/Smith* reasoning now will apply in any state with a medical consent statute which the courts have interpreted as granting minors authority over treatments associated with pregnancy,<sup>238</sup> regardless of that state's pre-existing abortion laws.

There may also be a constitutional basis for the principle that minors have the right to consent to (or refuse) abortions even in states without specific medical consent statutes. While the Court specifically refused to consider the validity of statutes requiring parental or paternal consent,<sup>239</sup> Justice Blackmun located a right of privacy in the fourteenth amendment's concept of personal liberty.<sup>240</sup> The Court held that a state had the power to impinge upon the woman's fundamental right to control what is done to her body only when the state's interest was sufficiently compelling and regulations of the procedures were narrowly drawn.<sup>241</sup> The only state interests deemed adequately compelling were the pregnant woman's health at the end of the first trimester and pre-natal life at the end of the second trimester. Therefore, unless the mere status of minority serves to limit a woman's fourteenth amendment rights, or the state is found to have some other compelling interest satisfied by granting the parents authority superior to that of the pregnant minor to decide

235. 410 U.S. 113 (1973).

236. 410 U.S. 179 (1973).

237. *Roe* prohibited all state regulation of abortion during the first trimester. 410 U.S. at 163. See also text accompanying notes 216 & 217 *supra*.

238. See statutes cited in note 209 *supra*. Query whether the medical consent statutes in Hawaii and Missouri (see note 210 *supra*) are still valid.

239. *Roe v. Wade*, 410 U.S. at 165 n.67.

240. *Id.* at 152-53.

241. *Id.* at 162-63. See generally *Developments in the Law—Equal Protection*, 82 Harv. L. Rev. 1065 (1969). Essentially the doctrine provides that statutory classifications which differentiate between groups of people otherwise similarly situated by reliance upon "suspect" criteria (e.g., race, see *Korematsu v. United States*, 323 U.S. 214, 216 (1944)) or by affecting a group of persons' "fundamental interests" (e.g., procreation, see *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942)) will be held unconstitutional as a denial of equal protection unless justified by a "compelling" state interest.



whether she should bear a child, any state regulation beyond that approved in *Roe* should be held unconstitutional.<sup>242</sup>

The principle that minors are full-fledged citizens within the meaning of the fourteenth amendment and the Bill of Rights was affirmed by the Supreme Court's decision in *In re Gault*.<sup>243</sup> In addition, there are a variety of other situations in which the Court has extended basic constitutional guarantees to minors.<sup>244</sup>

The Supreme Court, however, has never directly confronted the issue of a minor's rights vis à vis his parents where the two conflict.<sup>245</sup> This dearth of case law is due at least in part, to an express or implied unity of interest between the parent and child. Recently, however, the validity of this theoretical merger of interests has been disputed in several contexts.<sup>246</sup>

One lower court case, *Matter of P.J.*,<sup>247</sup> clearly acknowledged that the mere status of minority should not render a person incompetent to make an abortion decision. The court ruled that a seventeen year-old be permitted to have an abortion despite the objections of her mother, who had cared for her daughter's first child. The court not only looked to the pregnant minor's own ability to give an informed consent, but also noted the disparity between her religious beliefs and those of her parents:

[T]he court has found that although a juvenile, and despite her age, Respondent's status was one of quasi-emancipation; her degree of maturity and knowledge was such that she fully understood the nature of the operation, how the operation is performed, and effects of such an operation; and that having an abortion does not violate any of her religious beliefs, which are distinguished from those of her parents.<sup>248</sup>

242. See *Coe v. Gerstein*, Civ. No. 72-1842 (S.D. Fla. Aug. 13, 1973), discussed at notes 257-70 *infra* and accompanying text.

243. 387 U.S. 1 (1969). The *Gault* court specifically rejected the idea that any alleged societal benefits resulting from informal juvenile court procedures constituted a valid basis for depriving a minor of the right to procedural due process, and stated that "neither the Fourteenth Amendment or the Bill of Rights is for adults alone." *Id.* at 13.

244. See, e.g., *In re Winship*, 397 U.S. 358 (1970) (proof beyond a reasonable doubt standard to be applied in juvenile court); *Tinker v. Des Moines School Dist.*, 393 U.S. 503 (1969) (freedom of speech for students); *Board of Educ. v. Barnette*, 319 U.S. 624 (1943) (compulsory pledge of allegiance declared unconstitutional).

245. For a forceful argument in support of the theory that a child should be the constitutional equal of an adult, see Kaimowitz, *Legal Emancipation of Minors in Michigan*, 19 Wayne L. Rev. 23 (1972).

246. See *Wisconsin v. Yoder*, 406 U.S. 205, 241 (1972) (Douglas, J., dissenting in part). The majority held they did not need to reach the issue of a possible conflict between parent and child. *Id.* at 231. Cf. *Rowan v. United States Post Office Dep't.*, 397 U.S. 728, 730 n.1 (1970).

247. 12 Cr. L. Rptr. 2549 (D.C. Super. Ct. Feb. 6, 1973).

248. *Id.*

The court's emphasis on a totality of factors, rather than age alone,<sup>249</sup> was an adaptation of a recognized approach for determining a given minor's maturity and his or her competence to be treated as an adult. This method traditionally has been used in cases concerning the effectiveness of waivers of minors' constitutional rights.<sup>250</sup> There is therefore a suggestion that some courts have afforded broad constitutional protections to minors; in the proper instances courts will not permit parental waiver of minor's rights without a factual determination that the child is incompetent to rationally comprehend the situation. Thus, under this line of authority, if a mature minor is competent to waive certain constitutional rights, logically he must possess the capacity necessary to assert them.

If it is assumed for the purposes of this analysis that the mere status of minority does not have a detrimental effect on a person's constitutional rights, it follows that a parental consent requirement will pass constitutional muster only if it serves a compelling state interest. The two justifications most frequently advanced are the need to protect the minor from her own improvidence and the importance of preserving the family unit by sustaining the primacy of parental control.<sup>251</sup>

The first justification is immediately suspect in any state where the legislature has lowered or abolished the age of consent for any medical treatments since these states theoretically have conceded already that minors are capable of making informed decisions regarding their own health. Moreover, if a woman is pregnant it is too late to "save" her from improvident sexual activity. To deny her a desired abortion is to suggest that she is not mature enough to make that decision, but is mature enough to give birth to, and care for, a child.<sup>252</sup>

Finally even assuming that the state's interest in protecting minors

249. See Stern, *Furnishing Information and Medical Treatment to Minors for Protection, Termination and Treatment of Pregnancy*, 5 *Clearinghouse Rev.* 131, 153 (July 1971).

250. See, e.g., *People v. Lara*, 67 Cal. 2d 365, 432 P.2d 202, 62 Cal. Rptr. 586 (1967), declaring that the validity of a minor's confession made without the presence of counsel or other responsible adult "depend[ed] not on his age alone, but on a combination of that factor with other circumstances such as his intelligence, education, and ability to comprehend the meaning and the effect of his statement." *Id.* at 383, 432 P.2d at 215, 62 Cal. Rptr. at 599. See also *McBride v. Jacobs*, 247 F.2d 595 (D.C. Cir. 1957); *Shioutakon v. District of Columbia*, 236 F.2d 666 (D.C. Cir. 1956), holding that parental waiver of a minor's rights will be effective only where the minor is incapable of making a waiver and the interests of parent and child are not adverse.

251. Pilpel and Zuckerman, *Abortion and the Rights of Minors*, 23 *Case W. Res. L. Rev.* 779, 799-800 (1972).

252. In addition there is the possibility that denied a medically safe, legal abortion, a young woman would seek the services of an illegal and unsafe abortionist rather than consult her parents.

from their own improvidence is deemed compelling, the state cannot sustain a restriction on constitutionally protected activity unless the government has chosen a relatively unburdensome mode of furthering that interest.<sup>253</sup> Any consent statute isolating all women below a certain age sweeps too broadly because it fails to take into account the truly relevant factors—the emotional maturity and intellectual capacity of a female minor—of giving an informed consent.<sup>254</sup> Anyway, a statutory presumption that age has its correlate in maturity is not only factually incorrect, but under recent Supreme Court decisions would raise serious due process questions.<sup>255</sup>

The second justification offered might be that requiring parental consent fosters parental control and thereby sustains the family unit. Referring once again to numerous medical consent statutes, we find legislatures often have determined that parental control is of secondary importance where a minor's health is at stake. Furthermore, in many cases, a minor's pregnancy is a de facto indication of a pre-existing failure of parental control, which can hardly be remedied by a parental consent statute. Moreover to assert this justification after the fact and force these women to bear unwanted children is merely cruel and possibly unconstitutional punishment of unlucky girls for illicit intercourse.<sup>256</sup>

Portions of the constitutional analysis stemming from *Roe v. Wade* were employed recently by the United States District Court for the Southern District of Florida in *Coe v. Gerstein*.<sup>257</sup> The court struck down Florida's "spousal and parental consent" requirement<sup>258</sup> on behalf of two

253. See, e.g., *Dunn v. Blumstein*, 405 U.S. 330, 343 (1972) (Marshall, J.).

254. But see note 199 *supra* and accompanying text. See also Stern, *supra* note 249, at 152 n.14.

255. See *Vlandis v. Kline*, 412 U.S. 441 (1973); *Stanley v. Illinois*, 405 U.S. 645 (1972); *Bell v. Burson*, 402 U.S. 535 (1971); *Pilpel, Minors' Rights to Medical Care*, 36 Albany L. Rev. 462, 464 (1972).

256. See *Eisenstadt v. Baird*, 405 U.S. 438 (1972), rejecting the argument that the Massachusetts birth control statute which prohibited the prescription of contraceptives to unmarried persons aided enforcement of its anti-fornication statute. Cf. *State v. Baird*, 50 N.J. 376, 383, 235 A.2d 673, 677 (1967), where Chief Judge Weintraub, concurring, stated that "to prescribe . . . [an unwanted pregnancy] . . . as a punishment for illicit intercourse would be a monstrous thing." But see *Doe v. Planned Parenthood Ass'n of Utah*, 29 Utah 2d 356, 510 P.2d 75 (1973), upholding a statute which prohibited minors from obtaining contraceptive services without parental consent.

257. Civ. No. 72-1842 (S.D. Fla. Aug. 13, 1973).

258. Fla. Stat. Ann. § 458.22(3) (Supp. 1973):

One of the following shall be obtained by the physician prior to terminating a pregnancy:

(a) The written request of the pregnant woman and, if she is married, the written consent of her husband, unless the husband is voluntarily living apart from the wife, or

(b) If the pregnant woman is under eighteen years of age and unmarried, in addition to her written request, the written consent of a parent, custodian or legal guardian must be obtained, or

females each pregnant for less than three months. One of the plaintiffs, Patricia Noe, was an unmarried minor unable to obtain parental consent for a therapeutic abortion.<sup>259</sup>

The court noted at the outset that *Roe v. Wade* and *Doe v. Bolton* dealt specifically with the state's interest in the protection of maternal and fetal health and did not address the interests of third parties, such as the father or husband and the parents.<sup>260</sup> The court reasoned that the state was proscribed from imposing any regulations (even those made on behalf of the fetus' father or grandparents) which had as their purposes the interests enumerated in *Roe*, except at times and in manners therein provided.<sup>261</sup> However, if Florida had demonstrated that the third party interests, which were to be protected by its statute, attached at the time of conception and fell completely outside the categories of protection of maternal health and potential life, the court would have conceded that *Roe* was not controlling.<sup>262</sup>

The court recognized that the interest of the husband or parent in the pregnant wife or daughter and the fetus which she carries is qualitatively different from the interest which the state may constitutionally assert.<sup>263</sup> Nevertheless, even if such compelling parental and paternal interests existed from the moment of conception, the court held that the statute was fatally defective:

... [I]t is apparent that not all paternal or parental interests fall outside the categories of protection of maternal health and potential life. . . . The failure of the Florida "spousal or parental consent requirement" is that it gives to husbands and parents the authority to withhold consent for abortions for any reason or no reason at all.<sup>264</sup>

The court concluded that since the state cannot interfere with a woman's right of privacy in the first trimester to protect her health, or before viability to protect the fetus, it cannot delegate to third parties an authority it does not possess.<sup>265</sup>

Although the decision reaches an admirable result and is in keeping with recent trends in the area of juvenile rights, its reasoning may be

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(c) Notwithstanding paragraphs (a) and (b) of this subsection, a physician may terminate a pregnancy provided he has obtained at least one corroborative medical opinion attesting to the medical necessity for emergency medical procedures and to the fact that to a reasonable degree of medical certainty the continuation of the pregnancy would threaten the life of the pregnant woman.

259. Civ. No. 72-1842, at 2. The other plaintiffs were several physicians practicing family medicine and Nancy Coe, a pregnant married woman unable to obtain her husband's consent to an abortion. Id.

260. Id. at 3 & n.4.

261. Id. at 4.

262. Id.

263. Id. at 4-5.

264. Id. at 5.

265. Id. at 6.

vulnerable to some critical comment. The court, for instance, stated categorically that "a pregnant woman under 18 years of age cannot, under the law, be distinguished from one over 18 years of age in reference to 'fundamental,' 'personal' constitutional rights,"<sup>266</sup> but failed to consider that the Supreme Court's reasoning in *Roe* might lead to a broader right for minors than adults. For instance, application of the *Roe* concept of "trimester" time periods might be inappropriate for minors. For an older woman, the dangers of carrying a baby to term may be greater than having an abortion within the first trimester. Since the dangers of pregnancy and childbirth increase as age decreases to a certain point,<sup>267</sup> abortion might be a comparatively safer procedure for young minors even beyond the parameters of the first trimester.

An interest mentioned by the court which admits of unique application to minors is that of the preservation and primacy of the family unit. Although reasons previously mentioned<sup>268</sup> indicate the shortcomings of this approach, the court does little more than imply that this justification may be insufficient to sustain the statute merely because it is reasonably related to protection of maternal health and potential life. The court's opinion, therefore, could have been strengthened had it distinguished the state's interest in regulating the abortions of minors from that in regulating adults.

A thorough analysis of permissible third party interests would entail a consideration of those private interests whose existence is not dependent upon a grant of authority from the state,<sup>269</sup> as well as those which the state may create through a delegation of its power. The court does not address the enforceability of this first class of interests, probably because its scrutiny is focused on the Florida statute. With respect to the latter class, the court seems to recognize the possibility of state regulation which would allow consent to be withheld within the first trimester for reasons other than protection of maternal health and potential life, if the existence of such reasons could be demonstrated. Although this might seem to open the door for amended regulations, the difficulties presented by such an alternative are well documented in a footnote by the court:

Because of the practical problems involved in drafting or enforcing a statute which would exclude interests related to maternal health in the first trimester, we are inclined to agree with Mr. Justice Rehnquist (dissenting) that

266. *Id.*

267. See Guttmacher, *The Genesis of Liberalized Abortion*, 23 *Case W. Res. L. Rev.* 756, 768 (1972).

268. See note 256 *supra* and accompanying text.

269. Civ. No. 72-1842, at 6. See text accompanying note 265 *supra*. Cf. *Evans v. Newton*, 382 U.S. 296 (1966); *Shelley v. Kraemer*, 334 U.S. 1 (1948).

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as a practical matter, "a state may impose virtually no restrictions on the performance of abortions during the first trimester of pregnancy." *Roe v. Wade*, 93 S. Ct. at 736, 270

Although the court reaches a laudable and timely result while confronting a number of significant and difficult issues, its opinion would have had even greater ramifications for minors' rights had it more carefully applied *Roe's* reasoning and more explicitly responded to the possibility of third party interests unique to a minor woman.

*Authority to Consent—When Parent and State Disagree.*—The juvenile courts, the primary forum for the determination of minors' rights, traditionally possessed only weak common law bases upon which to rest their jurisdiction when they sought to order medical treatment for infants over parental objections.<sup>271</sup> In an effort to alleviate this problem, states have enacted civil statutes, based on their police power, granting the courts authority to deprive a parent of custody where an infant is found to be "neglected," "dependent," or in need of "necessaries."<sup>272</sup> Thus, the question of a state's privilege to order corrective or preventative non-emergency medical care for infant citizens has become largely one of statutory interpretation.<sup>273</sup>

270. Civ. No. 72-1842, at 6 n.6.

271. Courts have used the theories of *parens patriae* (see, e.g., *Johnson v. State*, 18 N.J. 422, 430-31, 114 A.2d 1, 5 (1955); Note, *Compulsory Medical Treatment and the Free Exercise of Religion*, 42 Ind. L.J. 386, 390-91 n.30 (1967); 64 Mich. L. Rev. 554, 555 n.5 (1966)), the provision of "necessaries" (see, e.g., *Pickering v. Gunning, Palmer, Delinquency, Guides to the Judge in Medical Orders Affecting Children*, 14 Crime & Delinq. 109-10 (1968); *Justice v. State*, 116 Ga. 605, 606, 42 S.E. 1013, 1014 (1902) (holding that necessary sustenance does not include medical care)) or an affirmative duty to protect life (see, e.g., *Application of President and Directors of Georgetown College*, 331 F.2d 1000, 1008 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964); *Hoener v. Bertinato*, 67 N.J. Super. 517, 171 A.2d 140 (Juv. & Dom. Rel. Ct. 1961). See also *John F. Kennedy Mem. Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971). But see *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962)). Some states also had enacted penal laws to compel parents to provide adequate medical care, but these provisions contain the inherent deficiency that often they were applicable only after irreparable harm had befallen the child. See *People v. Pierson*, 176 N.Y. 201, 60 N.E. 243 (1903); *Craig v. State*, 220 Md. 590, 155 A.2d 684 (1959); *Mitchell v. Davis*, 205 S.W.2d 812 (Tex. Civ. App. 1947). See generally Note, *Court Ordered Non-Emergency Medical Care for Infants*, 18 Clev.-Mar. L. Rev. 296 (1969); 41 U. Cin. L. Rev. 961, 963 (1972).

272. See, e.g., Cal. Welf. & Inst'n Code § 600 (West 1972); Conn. Gen. Stat. Rev. § 17-59 (Supp. 1973); Md. Ann. Code art. 26, § 70-1(j) (Supp. 1973); Mo. Rev. Stat. § 211.031 (1959); N.J. Rev. Stat. § 2A:4-34 (1951); N.D. Cent. Code § 27-20-02 (1960); Ohio Rev. Code Ann. § 2151.04 (Page 1968); Wash. Rev. Code Ann. § 13.04.010(12) (1962).

273. The traditional procedure used for obtaining such medical orders involves a finding of neglect which arguably stigmatizes parents as unfit to care for their child.

The New York family court jurisdiction was contested in *Matter of Sampson*,<sup>274</sup> a case involving a fifteen year-old boy, Kevin Sampson, who was victim of an extensive neurofibromatosis, or Von Recklinghausen's disease, which manifested itself in the massive deformity of his face and neck. The Commissioner of Health of Ulster County brought a proceeding pursuant to Article 10 of the Family Court Act<sup>275</sup> charging the child's mother, Ms. Sampson, with neglect because she had objected to blood transfusions necessary for safe performance of corrective surgery on the child.<sup>276</sup> The family court held that it possessed the jurisdictional (both statutory<sup>277</sup> and constitutional<sup>278</sup>) authority to protect the child's welfare by ordering the blood transfusions,<sup>279</sup> despite Ms. Sampson's religious<sup>280</sup> and medical<sup>281</sup> objections and the physicians' counsel that surgical risk would decrease with age.<sup>282</sup> The court based its conclusion on the serious psychological impairment which might result from such conspicuous

*Santos v. Goldstein*, 16 App. Div. 2d 755, 227 N.Y.S.2d 450, motion for leave to appeal dismissed, 12 N.Y.2d 672, 185 N.E.2d 904, 233 N.Y.S.2d 465 (1962), emphasized that a mere court order for medical treatment did not indicate the parents were unfit or had neglected their child in the traditional sense. Accord, *Matter of Sampson*, 65 Misc. 2d 658, 676, 317 N.Y.S.2d 641, 658 (Family Ct. 1970), *aff'd*, 37 App. Div. 2d 668, 323 N.Y.S.2d 253 (1971), *aff'd per curiam*, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972). See notes 274-303 *infra* and accompanying text. One proposal recommends that such statutes provide for emergency medical procedure entirely divorced from any concept of "neglect." Council of Judges, National Council on Crime and Delinquency, *Guides to the Judge in Medical Orders Affecting Children*, 14 *Crime & Delinq.* 109, 117 (1968).

274. 65 Misc. 2d 658, 317 N.Y.S.2d 641 (Family Ct. 1970), *aff'd*, 37 App. Div. 2d 668, 323 N.Y.S.2d 253 (1971), *aff'd per curiam*, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972).

275. See note 277 *infra*.

276. 65 Misc. 2d at 658, 661, 317 N.Y.S.2d at 643, 645.

277. *Id.* at 663-64, 317 N.Y.S.2d at 647-48. See N.Y. Const. art. 6, § 13(b); N.Y. Family Ct. Act §§ 115, 115(b), 232(a), 232(b), 232(c), 1011, 1012, 1013 (McKinney Supp. 1973).

278. 65 Misc. 2d at 665-69, 317 N.Y.S.2d at 649-52. See U.S. Const. amend. I; N.Y. Const. art. 1, § 3.

279. 65 Misc. 2d at 671, 676, 317 N.Y.S.2d at 654, 658. The court believed the state had a paramount duty to insure Kevin's "right to live and grow up without disfigurement." *Id.* at 669, 25 N.Y.S.2d at 652.

280. Jehovah's Witnesses hold as a cardinal principle of their faith that the law of God explicitly forbids the eating or ingestion of blood into the body by any means whatever, including modern surgical procedures for the transfusion of blood. Watchtower Bible and Tract Society, *Blood, Medicine and the Law of God* (1961); *State v. Perricone*, 37 N.J. 463, 181 A.2d 751 (1962), cited in 65 Misc. 2d at 662, 317 N.Y.S.2d at 646.

281. The court identified several potential complications: mismatching of incompatible blood types; circulatory overload or air embolism caused by inept procedures; transmission of diseases such as syphilis, malaria and hepatitis from blood obtained through commercial blood banks. 65 Misc. 2d at 662, 317 N.Y.S.2d at 646.

282. The bigger one grows physically, the smaller the blood loss will be proportional to the total blood supply. *Id.* at 672, 317 N.Y.S.2d at 655.

deformity,<sup>283</sup> and, indeed, had already been reflected in Kevin's "low self concept."<sup>284</sup>

Initially addressing its lf to Ms. Sampson's religious objections, the court contrasted the absolute right to believe as one chooses, with the limited right to act on those beliefs where the public health or welfare is concerned.<sup>285</sup> The cases cited in the decision, however, represented only debatable precedent for the court's thesis that the state's power to order blood transfusions overrides religious objections since the earlier cases had specifically involved life-saving treatments.<sup>286</sup>

The court next weighed the potential benefit from such an operation against the risk involved. Citing *Matter of Rotkowitz*<sup>287</sup> for the proposition that the child's life need not be endangered to justify judicial interference, the court found that more than adequate potential benefit existed to outweigh the inherent hazards of surgery.<sup>288</sup> Here again, however, this precedent was weak support for the *Sampson* decision since the operation in *Rotkowitz* was far less serious than that in *Sampson* and other facts rendered the cases distinguishable. Moreover, the *Rotkowitz* court itself had stretched the holding of the seminal New York opinion, *Matter of Vasko*.<sup>289</sup> *Vasko*, unlike either *Rotkowitz* or *Sampson* concerned a malady which if uncorrected, would probably have resulted in death.<sup>290</sup>

The only other precedent for the New York court was the dissenting

283. Although during the trial, medical testimony indicated no evidence of thinking disorder, no outstanding personality aberration, and no immediate threat to his sight or hearing (id. at 659-60, 317 N.Y.S.2d at 643-44), Kevin did remain virtually illiterate because he had been exempted from school since age nine by reason of his facial disfigurement.

284. Id. at 660, 317 N.Y.S.2d at 644.

285. *Prince v. Massachusetts*, 321 U.S. 158 (1944); *Cantwell v. Connecticut*, 310 U.S. 296 (1940); *Davis v. Beason*, 133 U.S. 333 (1890); *Reynolds v. United States*, 98 U.S. 145 (1878).

286. See *People ex rel. Wallace v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769, cert. denied, 344 U.S. 824 (1952); *Morrison v. State*, 252 S.W.2d 97 (Mo. Ct. App. 1952); *Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964); *State v. Perricone*, 37 N.J. 463, 181 A.2d 751 (1962); *Hoener v. Bertinato*, 67 N.J. Super. 517, 171 A.2d 14 (Juv. & Dom. Rel. Ct. 1961); *Santos v. Goldstein*, 16 App. Div. 2d 766, 227 N.Y.S.2d 450, motion for leave to appeal dismissed, 12 N.Y.2d 672, 185 N.E.2d 904, 233 N.Y.S.2d 465 (1962); *In re Clark*, 21 Ohio Op. 2d 86, 185 N.E.2d 128, 90 Ohio L. Abs. 21 (C.P. 1962).

287. 175 Misc. 948, 25 N.Y.S.2d 624 (Dom. Rel. Ct. 1941). The *Rotkowitz* court ordered surgery to stabilize a child's right foot, thereby preventing aggravation and extension of a deformity. The operation, however, was not serious, the child's mother favored the treatment and the father's objections were not religious. Id. at 951, 25 N.Y.S.2d at 627.

288. 65 Misc. 2d at 669-70, 674-75, 317 N.Y.S.2d at 653-54, 657-58.

289. 238 App. Div. 128, 263 N.Y.S. 552 (1933).

290. The child suffered from a malignant growth of the eye. Id. at 130-31, 263 N.Y.S. at 555.

opinion by Judge Stanley Fuld in *Matter of Seiferth*,<sup>291</sup> a case in which the court of appeals reversed a lower court order for corrective surgery. In attempting to distinguish a case closely analogous on its facts, the *Sampson* court argued that its powers had been expanded by a new section of the Family Court Act,<sup>292</sup> giving the family court jurisdiction to order certain care or treatment for physically handicapped children. In addition, the court reasoned that the legislative intent of a recent revision of Article 10 of the Family Court Act<sup>293</sup> conferred upon the court the "broadest power and discretion" to deal with abused and neglected children.<sup>294</sup> The *Sampson* court, however, overlooked the fact that the Children's Court Act, in force when *Seiferth* was decided, had given that court the undisputed power to order "necessary" surgery for neglected children.<sup>295</sup>

The New York Court of Appeals affirmed the *Sampson* ruling and endorsed the Family Court's assumption of broad authority and use of discretion<sup>296</sup> in rejecting parents' religious objections. Relying upon a decision<sup>297</sup> construing a Washington state statute,<sup>298</sup> the New York appellate court followed the trial judge's lead by also ignoring the distinction between life-saving treatments<sup>299</sup> and the less extreme procedures at bar or in *Rotkowitz*.

It is well settled that a person's right to practice religion freely does not include the liberty to expose the community or his child to communicable disease.<sup>300</sup> Similarly, where a child's life is imperiled by his parents' refusal to provide medical care, courts uniformly have been

291. 309 N.Y. 80, 86, 127 N.E.2d 820, 823 (1955). The court of appeals found that a congenital hair lip and cleft palate, causing disfigurement, a marked speech defect and emotional and psychological sensitivity, did not give rise to such an emergent and serious condition as would threaten the child's life or health.

292. "Whenever a child within the jurisdiction of the court appears to the court to be in need of medical, surgical, therapeutic, or hospital care or treatment, a suitable order may be made therefore." N.Y. Family Ct. Act § 232(b) (McKinney Supp. 1973). The statute had been enacted after the *Seiferth* decision.

293. N.Y. Family Ct. Act §§ 1011-72 (McKinney Supp. 1973).

294. 65 Misc. 2d at 671, 317 N.Y.S.2d at 654.

295. "[N]eglected child" shall mean a child . . . whose parents, guardian or custodian neglect and refuse, when able to do so, to provide necessary medical, surgical, institutional or hospital care for such child." Law of April 10, 1922, ch. 547, § 2(4), [1922] N.Y. Children's Ct. Act (repealed 1962).

296. *Seiferth* was held to have "impliedly or expressly recognized the court's power to direct surgery even in the absence of risk to the physical health or life of the subject or to the public." 29 N.Y.2d 900, 901, 278 N.E.2d 918, 919, 328 N.Y.S.2d 686, 687 (1972).

297. *Jehovah's Witnesses in the State of Washington v. King County Hosp.*, 278 F. Supp. 488 (W.D. Wash. 1967), aff'd per curiam, 390 U.S. 598 (1968). This court overruled a Jehovah's Witnesses' objections to a statute which empowered a court to order medical care for children found "grossly and willfully neglected as to medical care necessary for well being."

298. Wash. Rev. Code Ann. §§ 13.04.010 (1962), 13.04.095 (Supp. 1972).

299. See 278 F. Supp. at 503 n.10 (blood transfusions).

300. See, e.g., cases cited in note 305 infra.

willing to order appropriate relief.<sup>301</sup> *Sampson*, however, represents an expansion of judicial power which previously had been hinted at almost exclusively by other New York cases.<sup>302</sup> Although the initial response to the *Sampson* opinion is one of relief that aid will be granted a boy who, due to a religious tenet embraced by his parents, might have been forced to endure a massive physical deformity throughout his life, the court's intervention has other theoretical ramifications. Essentially, it signals an anomalous return to paternalism or "best interests" adjudication,<sup>303</sup> contrary to the general trend demonstrated by this article.

In express contrast to the New York approach, the Supreme Court of Pennsylvania, in *In re Green*,<sup>304</sup> recently held that a mother's religious objections to medical treatment for her son whose life was not in immediate danger should prevail over the state's interests in the child.<sup>305</sup> Ricky Ricardo Green, sixteen years old, was a two-time victim of polio attacks which had resulted in obesity and 94 per cent curvature of the spine and prevented him from walking or standing.<sup>306</sup> Although remedial surgery had been recommended, Ms. Green, a Jehovah's Witness, had refused to consent to the treatment because of her religious objections to the necessary blood transfusions. While the Pennsylvania court acknowledged the Commonwealth's position that the neglect statutes<sup>307</sup>

301. See, e.g., *Jehovah's Witnesses in the State of Washington v. King County Hosp.*, 278 F. Supp. 488 (W.D. Wash. 1967), aff'd per curiam, 390 U.S. 598 (1968); *Brooklyn Hosp. v. Torres*, 45 Misc. 2d 914, 258 N.Y.S.2d 621 (Sup. Ct. 1965); *Matter of Vasko*, 238 App. Div. 128, 263 N.Y.S. 552 (1933); cases cited in *In re Green*, 448 Pa. 338, 292 A.2d 387, 390 (1972).

302. See, e.g., *Matter of Rotkowitz*, 175 Misc. 948, 25 N.Y.S.2d 624 (Dom. Rel. Ct. 1941). Cf. *In re Karwath*, 199 N.W.2d 147 (1972); *In the Matter of the Comm'r of Social Serv. on behalf of Michael D. v. Bette D.*, 72 Misc. 2d 428, 339 N.Y.S.2d 89 (Family Ct. 1972); *In re Carstairs*, 115 N.Y.S.2d 314 (Dom. Rel. Ct. 1952); *In re Weintraub*, 166 Pa. Super 342, 71 A.2d 823 (1950).

303. See especially 65 Misc. 2d at 675, 317 N.Y.S.2d at 657-58, where the court explicitly grants all discretion to the surgeons without reserving to the patient or his representative any power or right of informed consent. Compare, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), and other cases discussed in Part I of this article supra.

304. 448 Pa. 338, 292 A.2d 387 (1972).

305. 448 Pa. at 392, 292 A.2d at 392. One legitimate state interest exists even if the child's life is not imperiled if his condition threatens society in a manner distinct from its effect on him. See cases involving court ordered vaccinations, e.g., *Zucht v. King*, 260 U.S. 174 (1922); *Jacobson v. Massachusetts*, 197 U.S. 11 (1905); *Mannis v. State*, 240 Ark. 42, 398 S.W.2d 206, cert. denied, 384 U.S. 972 (1966); *Cude v. State*, 237 Ark. 927, 377 S.W.2d 816 (1964); *Wright v. DeWitt School Dist.*, 238 Ark. 906, 385 S.W.2d 644 (1965); *McCartney v. Austin*, 57 Misc. 2d 525, 293 N.Y.S.2d 188 (Sup. Ct. 1968), aff'd, 31 App. Div. 2d 370, 298 N.Y.S.2d 26 (1969). See also Comment, 27 Ark. L. Rev. 151, 153 (1973).

306. 448 Pa. at 392, 292 A.2d at 388.

307. A "neglected child" is "[a] child whose parent . . . neglects or refuses to provide proper or necessary . . . medical or surgical care" and may be committed "to the care, guidance and control of some reputable citizen of good moral character . . ."



could be construed to convey authority to a trial court to order medical treatment,<sup>308</sup> it held in favor of the child's mother because the free exercise clause of the first amendment<sup>309</sup> circumscribed the broad language of the state law.<sup>310</sup> Ultimately, however, the court remanded the case to determine Ricky's religious beliefs,<sup>311</sup> and reserved decision with respect to any possible parent-child conflict.<sup>312</sup>

The court adopted a test by which to evaluate the state's interest when it conflicted with a parent's religious views as to the proper care for a child; the state must show "a substantial threat to society"<sup>313</sup> to outweigh protections provided to individuals under the first amendment.<sup>314</sup> The court carefully distinguished cases in which the child's life was in danger,<sup>315</sup> declining to express any view on the results of their balancing test in such situations.<sup>316</sup> The majority viewed with horror the ramifications of discarding the fatal-nonfatal distinction as in *Sampson*. The Pennsylvania Court feared that to permit wide judicial discretion to make decisions merely on the basis of whether the treatments were "required"<sup>317</sup>

Pa. Stat. Ann. tit. 11, § 50-101 et seq. (Supp. 1973). See 448 Pa. at \_\_\_\_ nn.2 & 3, 292 A.2d at 388 nn.2 & 3.

308. 448 Pa. at \_\_\_\_ 292 A.2d at 388.

309. "Congress shall make no law respecting the establishment of religion. . . ."

U.S. Const. amend. I.

310. See 448 Pa. at \_\_\_\_ 292 A.2d at 388-91.

311. Id. at \_\_\_\_ 292 A.2d at 392. This procedure was consistent with the majority's view of Justice Douglas' dissent in *Wisconsin v. Yoder*, 406 U.S. 205, 241 (1972) (see note 314 infra) and recent Pennsylvania extensions of the rights of minors in various contexts. See, e.g., *Commonwealth v. Moses*, 446 Pa. 350, 287 A.2d 131 (1971); *Falco v. Pados*, 444 Pa. 372, 282 A.2d 351 (1971); *In re Snellgrose*, 432 Pa. 158, 247 A.2d 596 (1968).

312. 448 Pa. at \_\_\_\_ 292 A.2d at 392. See *In re Green*, 452 Pa. 373, 307 A.2d 279 (1973), affirming trial court's finding after the evidentiary hearing on remand that Ricky did not want the surgery because of religious and medical reasons.

313. Id. at \_\_\_\_ 292 A.2d at 389, and alluding to *Sherbert v. Verner*, 374 U.S. 398, 403 (1963). See note 305 supra.

314. See *Wisconsin v. Yoder*, 406 U.S. 205, 233-34 (1972), where the Supreme Court held that the free exercise clause barred the application of a compulsory education statute to the members of the Amish sect. See Comment, 11 *Duquesne L. Rev.* 440, 446 (1973), which posited an alternative to the "substantial threat to society" requirement to justify judicial interference. The court should inquire: (1) Will the state be subjected to additional burdens by refusing to order the operation, and (2) Are the child's parents aware of all the consequences of not ordering the operation?

315. See 448 Pa. at \_\_\_\_ 292 A.2d at 390 and cases cited therein. In particular, the court distinguished *Jehovah's Witnesses in the State of Washington v. King County Hosp.*, 278 F. Supp. 488 (W.D. Wash. 1967), aff'd per curiam, 390 U.S. 598 (1968), on the ground that the prior case involved the application of a statute where children's lives were in imminent danger. But see the *Sampson* court's use of *King County Hosp.*, notes 297-99 supra and accompanying text. Cf. *Wisconsin v. Yoder*, 406 U.S. 205, 233-34 (1972), which relied upon *Application of President & Directors of Georgetown College*, 321 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964), which involved life-saving treatment for an adult. 448 Pa. at \_\_\_\_ 292 A.2d at 390.

316. 448 Pa. at \_\_\_\_ 292 A.2d at 392.

317. See *Sampson*, 65 Misc. 2d at 671, 317 N.Y.S.2d at 654.

would cause "endless problems" in interpreting and equitably applying the rule to later cases.<sup>318</sup>

Justice Eagen wrote a vigorous dissent focusing on the majority's dichotomous analysis of the interests at stake, and found their opinion insufficiently solicitous of the health and well-being of Ricky Green.<sup>319</sup> Rejecting the majority's life or death emphasis as unsupported by the Pennsylvania statute<sup>320</sup> or the case law, Eagen noted that the decisions in both *Wisconsin v. Yoder*<sup>321</sup> and *Prince v. Massachusetts*,<sup>322</sup> each relied upon by the majority, employed only the word "health."<sup>323</sup> Justice Eagen's final disagreement with the majority centered on the infeasibility and impropriety of asking a dependent child to choose between the chance for a normal life and his parents' religious beliefs.<sup>324</sup>

While the logic of this dissent seems forceful and realistic, it fails to raise several additional available arguments. Eagen never directly confronted either the majority's central requirement of a "substantial threat to society" or their application of the standard.<sup>325</sup> It could have been argued that just as the child labor law upheld over religious objections in *Prince*<sup>326</sup> reflected a societal judgment that child labor in general was an evil to be avoided, child neglect statutes represent an analogous determination vis à vis parents' treatment of their children. Both types of statutes empower the state to act pursuant to its compelling interest of protecting the health and welfare of children.

Another available rebuttal to the majority's reasoning could have focused on their strained use of the *Yoder* decision.<sup>327</sup> Not only did the court rely upon dictum, ignoring express qualifications where health was concerned, but it also inadequately explained the *Yoder* court's failure to consider the children's views on the issues at bar.<sup>328</sup> The *Green* facts

318. 448 Pa. at \_\_\_, 292 A.2d at 392.

319. Id. at \_\_\_, 292 A.2d at 393.

320. See note 307 supra.

321. See note 314 supra.

322. 321 U.S. 158 (1944) (upheld child labor law over religious objections).

323. 448 Pa. at \_\_\_, 292 A.2d at 394-95.

324. Id. at \_\_\_, 292 A.2d at 395. See *Sampson*, 65 Misc. 2d at 672, 317 N.Y.S.2d at 655, relying on *Matter of Seiferth*, 309 N.Y. 80, 86-87, 127 N.E.2d 820, 823 (1955) (Fuld, J., dissenting). See Kleinfeld, *The Balance of Power Among Infants, their Parents and the State*, 4 Family L.Q. 320 (1970). "A great proportion of the decisions made by parents for children cannot meet with resistance because the child is too ignorant and unsophisticated to understand the ramifications of the decision and question it, or even to realize that legitimate alternatives were open and a decision was made." Id. at 424.

325. See 41 U. Cin. L. Rev. 961, 965-66 (1972).

326. See note 322 supra.

327. See 448 Pa. at \_\_\_, 292 A.2d at 390, and as pointed out in Justice Eagen's dissent, see notes 314, 321 & 323 supra and accompanying text.

328. See 448 Pa. at \_\_\_, 292 A.2d at 392. The *Green* court argued that it was the parents who were prosecuted for their religious beliefs in *Yoder*, whereas "it is the child rather than the parent in this appeal who is directly involved."

were analytically similar to those in *Yoder* since each case concerned parents motivated by religious beliefs who wanted to contradict expressed public policy in the treatment of their children. The *Yoder* result was understandable since long-term compulsory public education might well have had a significant impact on the religious beliefs of the Amish children. The likelihood that Ricky's medical care would have affected his religious beliefs was substantially smaller, however, since undergoing one surgical procedure does not usually result in changes in a person's views of society and religion. Therefore, such a rationale hardly supports his or his parents' deeper involvement in the decision-making process.

In striking contrast to both *Green* and *Sampson*, but more in line with the earlier cases involving parental objections to medical treatment for their children,<sup>329</sup> is *Interest of Henry Green*,<sup>330</sup> a decision concerning a six year-old boy who was suffering from sickle cell anemia, an incurable hereditary blood disease. The Milwaukee County Court, relying upon the mother's "reasonable" non-religious objections in lieu of her doctrinal views as a Jehovah's witness, refused to order highly recommended medical treatment. The court's analysis proceeded on two levels—who has the right to decide about the child's treatment, and under what limitations. The court held, *inter alia*, that parents' exercise of religious freedom was not superior to the interest of the state as *parens patriae* in protecting a child's welfare.<sup>331</sup> Nevertheless, the court held that parental discretion should control where there is doubt as to the "efficacy of the proposed medical procedures and great danger or risk of death to the child by the treatment proposed."<sup>332</sup> Although there was strong medical evidence attesting to the benefit of a blood transfusion, the court dismissed the neglect petition which had brought on the proceeding, since the mother's objections were logical, reasonable and made in good faith.<sup>333</sup> *Henry Green* represents relatively early judicial recognition that, rather than

329. See, e.g., *Matter of Seiferth*, 369 N.Y. 80, 127 N.E.2d 820 (1955) (which relied not upon the father's beliefs, but rather upon the child's resistance to the proposed treatments because of his indoctrination); *In re Tuttendario*, 21 Pa. Dist. 561, 562 (Phila. County Ct. 1911), noted in 14 *Crime & Delinq.* 107, 112 n.12 (1968); *Matter of Hudson*, 13 Wash. 2d 673, 126 P.2d 765 (1942). See also *In re Frank*, 41 Wash. 2d 294, 248 P.2d 553 (1952).

330. 12 *Crime & Delinq.* 377 (Child. Div. Milwaukee County Ct. Mar. 18, 1966).

331. 12 *Crime & Delinq.* at 382. A degree of parental discretion, however, was found to exist as a result of the ninth amendment and the judicially-developing right to privacy as interpreted in *Griswold v. Connecticut*, 381 U.S. 479 (1965). *Id.*

332. 12 *Crime & Delinq.* at 384.

333. *Id.* at 384-85. The court premised its decision against the treatment on the possible risks involved in blood transfusions which would at most prolong Henry's life, the serious doubt as to the usefulness of the proposed medical procedures which were new and experimental, and the inaccuracy of medical advice in the past which had incorrectly indicated a dire need for such transfusions. *Id.* Cf. *Kaimowitz v. Michigan Dep't of Mental Health*, Civ. No. 73-19434-AW (Mich. Cir. Ct. July 10, 1975), noted in 42 *U.S.L.W.* 2063. See notes 105-54 *supra* and accompanying text.

blindly adhering to medical testimony in all circumstances, courts should afford some probative value to parents' views, even when those ideas are in conflict with the physician's opinion. The numerous medical judgments necessitated by the court's test, however, highlight once again the difficulties encountered in resolving "medico-legal" questions in patients' rights litigation.<sup>334</sup>

Though we lament the fact that Ricky Green will not receive spinal surgery, the court's conclusion to allow a mentally alert sixteen year-old to have significant input in making his own health care decision seems completely defensible.<sup>335</sup> However, to the extent that the decision turns on *Ms. Greens'* first amendment rights, rather than Ricky's right to control his own body, the case's precedential value for minor's health rights is diminished. The *Sampson* decision, in contrast, permitting needed corrective surgery, achieves an admirable result for Kevin but unfortunately invokes the fear of a return to judicial paternalism reminiscent of the pre-*Gault* era.<sup>336</sup> This implication, however, may be mitigated by the facts of Kevin's case. Although the court never explicitly analyzed Kevin Sampson's competence to understand the nature of the procedure and to make an informed choice, his undeniable inability to do either probably played a determinative part in the court's decision. In *Henry Green*, the issue of the patient's own informed consent never arose because the child involved was too young to participate in the decision-making; the court instead gracefully avoided the subjective determination of Henry's best interests and looked instead to the "reasonableness" of his mother's objections. *Henry Green* utilized a balancing test in which the court considered many pertinent factors similar to those in the abortion decision *Matter of P.J.*<sup>337</sup>

#### CONCLUSION

This overview of many of the recent cases involving patients' rights demonstrates that definitive conclusions are difficult at best. The primary impression, by way of a partial disclaimer, must be that there is an enormous tension among the many weighty interests presented in this area of

334. See *Kaimowitz*, Civ. No. 73-19434-AW (Mich. Cir. Ct. July 10, 1973). See also cases such as *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), which confronts some of the difficulties encountered in trying to evaluate medical discretion. Finally, consider cases in which courts have issued, upon medical advice, emergency orders which have subsequently proved unnecessary. See, e.g., *Santos v. Goldstein*, 16 App. Div. 2d 755, 227 N.Y.S.2d 450, motion for leave to appeal dismissed, 12 N.Y.2d 672, 185 N.E.2d 904 (1962), 233 N.Y.S.2d 465 (1962); *In re Clark*, 21 Ohio Op. 2d 86, 185 N.E.2d 128, 90 Ohio L. Abs. 21 (C.P. 1962).

335. See final opinion of case after remand *In re Green*, 452 Pa. 373, 307 A.2d 279 (1973). See text accompanying note 311 *supra* and note 312 *supra*.

336. *In re Gault*, 387 U.S. 1 (1967).

337. 12 Cr. L. Rptr. 2549 (D.C. Super. Ct. Feb. 6, 1973). See notes 247-49 *supra* and accompanying text.

law: the intimate, personal rights of the patient, the schooled and concerned opinions of the physicians, the well-intentioned parental desire for their children's well-being, and the solicitude of the state for the health and welfare of its population. The decisions, practically uniform in their lack of articulate standards, reflect the enormity of the burden as well as the complexity of the determinations and, unfortunately, leave subsequent courts and commentators to inference. Some guidelines have, however, tentatively emerged. Judicial and legislative behavior have evidenced a trend toward the recognition of minors' capacity to consent to their own health care. This development is reflected not only in liberalized medical consent statutes but also in judicial solicitation of minors' views about the proposed treatment. As the questions become more complex, courts have begun to move away from deciding what is in the child's best interest and toward determining who shall make the decisions affecting a minor's life. In general, where the patient is mature and competent enough to understand the nature of the issues involved, the courts have increasingly deferred to his or her own wishes.

Nevertheless, looking to the future, one must make an ardent plea for more clearly explicated rationales in decisions involving patients' rights. In speculating, one might note that the title of a book written by a women's collective may prove to be an apt forecast of judicial determinations to come—*Our Bodies, Ourselves*.<sup>338</sup>

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338. Boston Women's Health Book Collective, *Our Bodies, Ourselves* (1973).



# ACCESS TO MEDICAL RECORDS

Dennis Helfman  
Glenn Jarrett  
Susan Lutzker  
Karen Schneider  
Peter Stein

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## Introduction

The present study collects, analyzes, and presents legal materials on Access to Medical Records.

The major headings of the material following are: Analysis, Summary and Collation of the State-by-State Study; Summary of Legal Literature; Selected Legal Bibliography; Selected Medical Bibliography; Suggestions for Future Study and The State-by-State Study.

The areas of inquiry selected for the State-by-State study were Physician-Patient Privilege; Public Records Acts; Medical Lien Acts; Required Reports; and Special Access Laws. These heading are used in this Introduction and in the Analysis, Summary, and Collation as well as in the State-by-State Study itself.

The State-by-State study contains a presentation of relevant statutes and cases. The Appendix contains a graphic tabulation of the results of the State-by-State Study.

## ANALYSIS OF THE BASIC LAW IN THE ABSENCE OF SPECIAL PROVISIONS

In the absence of special provisions or principles, medical records are the property of the doctor or a hospital maintaining them. However, the bundle of rights connoted by the word "property" never includes the right to do absolutely anything one wishes to do with his own property. For example: One's right to one's own automobile does not include a right to use the automobile to injure another; and in the case of medical records, the hospital cannot use the records in violation of the patient's right to privacy.

As with any property, the hospital and doctor's property right to the records is also qualified by the obligation we all have to produce our property if required pursuant to judicial process (e.g., a subpoena) for purposes of a law suit (either pretrial discovery or as trial evidence).

Property in records, be they business records or otherwise, is often qualified by another duty placed upon their owner: A duty to record certain information; to maintain and keep those records for a certain number of years; and to keep them open for inspection by certain regulatory agencies. Such is the case under the corporation laws of many states; under the Federal Securities Exchange Laws (respecting stock brokers); under departments of health laws in various states (respecting licensed hospitals); and under other regulatory and licensing schemes.

Because the property rights in medical records possessed by the doctor or hospital are those of the doctor or hospital, a doctor or hospital may refuse to disclose them to the patient or his legal representative, in the absence of court process or special law.

## FIVE HEADINGS USED IN THE STATE-BY-STATE PRESENTATIONS

### Physician-Patient Privilege

A legal prohibition against disclosure in litigation of confidential medical matters did not exist at common law, despite the existence of similar prohibitions governing marital and legal confidences. However, forty-three states today have enactments providing some form of such prohibition. Although variously phrased as an incompetency, prohibition, or privilege, the provision is nearly always construed as a privilege. That is, it may be asserted or waived by the patient or by someone on his behalf (e.g., the court, a lawyer, or the doctor or hospital). The primary impact of this "doctor-patient privilege" is at trial and during pre-trial discovery. In the absence of some special privilege such as this, it is basic law that documents or information in the possession of anyone must be surrendered if required by proper court process for the resolution or preparation of a controversy in litigation pursuant to valid discovery process or subpoena (subpoena duces tecum for documents) or similar court order or process, for purposes of pretrial discovery or trial evidence.

A proposal for a uniform body of Federal Evidence Rules presently pending before the Supreme Court of the

United States provides only for a psychotherapist-patient privilege, and no general doctor-patient privilege.

In a malpractice action, questions of privilege can arise in a number of ways. They can arise where the plaintiff or defendant is seeking records of a third party (e.g., to show the customary or non-customary nature of a procedure performed on the plaintiff, or to impeach the word of the third party as a witness). If the plaintiff himself is seeking his own records, the privilege will be waived insofar as his own access is concerned. If the defendant is seeking the plaintiff's records, the better (but by no means settled) view would be that plaintiff by instituting the action has waived his privilege as relevant records.

### Public Records Acts

Many States have so-called "Freedom of Information" acts providing that documents in the possession of state agencies shall be open to public inspection. As there are numerous state-run hospitals or medical facilities, the question arises as to whether medical records of patients therein are required to be open to the public. In most states, however, medical records are exempted from the acts.

### Lien Laws

Many states have statutes designed to help secure that a hospital treating a patient will receive payment therefor. These statutes provide that a hospital shall have a lien on amounts collected from a wrongdoer by the patient for his injury. In some states, not only hospitals, but treating physicians as well are accorded such a lien. The medical lien statutes generally provide that the hospital treating the injured person shall file notice of its charges in a public office or otherwise notify the injuring party of its charges and that if this is done, the hospital is entitled to receive its charges as a first priority (before the injured party gets anything) out of any settlement or recovery payable by the injuring party to the injured party. If the injuring party pays the injured party before the hospital charges are satisfied, rather than the hospital, the injuring party is liable to the hospital. The significance, for our purposes, of these laws is that they often permit the injuring party (i.e., the party notified of the lien or against whom the lien is asserted) to examine the hospital records of the injured party. The purpose of this is to enable the bona fides of the hospital's claim to be checked over and verified; but in a number of states, the authorization to inspect is not limited to financial records.

### Required Reports

Certain medical conditions may be required by law to be reported to a government agency by the treating physician or the patient (e.g., venereal disease, "battered" children, gunshot wounds or other violent injuries). As the entire medical background of a patient may become relevant in a medical malpractice action, these state agencies may be approached by a party or potential party to such an action, for information filed in a required record. The question

arises as to whether and to whom these records will be disclosed by the agency.

### Special Access Laws

Nine states have statutes specifically dealing with a patient's right of access to his medical records aside from any rights he may have under court process once litigation has commenced. Typically such statutes provide that the patient or his expressly authorized representative must be given access to his records. This heading also includes certain other legal matters in particular jurisdictions bearing on accessibility of medical records.

## Analysis, Summary and Collation of the Results of the Study

### I. PHYSICIAN-PATIENT PRIVILEGE

The physician-patient privilege, unlike that of attorney-client, did not exist at common law. However, 43 states and the District of Columbia, in order "to encourage confidence and preserve it inviolate" (Idaho Code §9-203; see also preamble to Montana and Utah provisions) have enacted statutes protecting from disclosure confidential communications between physicians and their patients (Connecticut, Florida, Kentucky, Maryland, Georgia and Tennessee restrict the privilege to psychiatrists. Alabama, Delaware, Rhode Island, Massachusetts, South Carolina, Texas and Vermont are the seven states having no general doctor-patient privilege statute).

#### Testimony v. Disclosure

Most of these laws state that a physician or surgeon may not be examined in a legal proceeding as to confidential patient communications. This type of language is susceptible to the interpretation that it applies only at trial, but courts have interpreted it to include discovery proceedings (depositions) as well.

The statutes of at least eight states speak of "disclosure" rather than testimony. The more recently-enacted statutes of California and Nevada afford the patient "a privilege to refuse to disclose, and prevent others from disclosing" confidential information.

#### "Communications" Defined

Usually, privilege statutes apply to communications by the patient to the doctor and/or information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient (e.g., North Carolina). The scope of the privilege is left in question by some statutes, such as that of West Virginia, which mentions only communications made by the patient to the doctor. Interpreted narrowly, this could mean only oral communications and not other medical records or information about the patient's condition acquired by other means such as tests or physical examination. If test and examination results are deemed "implied communications" from the patient, there

are still sources of information that may not be covered, e.g., sources other than the patient, but relating to the patient's case.

California's definition of confidential communication is quite elaborate, encompassing:

"information, including information obtained by examination of the patient, transmitted between a patient and his physician in the course of that relationship and in confidence by a means which, so far as the patient is aware, discloses to no third persons other than those who are present to further the interest of the patient in the consultation or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose for which the physician is consulted, and includes a diagnosis made and the advice given by the physician in the course of that relationship."

(CAL. EVID. CODE §992 [West Supp. 1971]).

The privilege is most narrowly applied in New Mexico (communications as to venereal or other "loathsome disease"), Kentucky (vital statistics) and Pennsylvania (information that tends to blacken the character of the defendant).

Many of the privilege statutes are explicitly limited to civil actions. Even if such a state has another statute or rule providing as a general matter that the rules of evidence applied in civil actions shall also apply in criminal cases, courts have held that the words "in civil actions" in the privilege statute indicate a legislative intent not to extend the privilege to criminal cases, especially since the privilege is in derogation of the common law (e.g., Montana and Oregon).

#### Exceptions

Many of the privilege statutes contain exceptions, the most significant of which is the automatic waiver of the privilege where the party's physical or mental condition is an element of a claim or defense or where the party's physical condition is in controversy. Such a statutory exception is applicable in at least twenty states, including Connecticut, New Jersey, Illinois, Michigan and Wisconsin. Five states (California, Colorado, Illinois, Michigan and Wisconsin) maintain a separate exemption for malpractice suits, although malpractice actions in other states would probably fall under the "physical condition in issue" exception.

The laws of Maine and Tennessee simply allow a court to compel disclosure where it deems it necessary for a proper administration of justice.

Many statutes explicitly provide that the privilege is waived if the party testifies as to the confidential communication or puts a physician on the stand to testify as to the party's physical or mental condition. In the absence of such a statutory provision, case law has frequently held that the privilege is waived by such testimony (See below).



Laws requiring the reporting of cases of suspected child-abuse also often provide for waiver of the privilege in proceedings concerning such cases.

Other situations where the privilege is waived by statute are proceedings to commit or establish competency, proceedings to test the validity of a will, proceedings involving the unlawful attempt to procure narcotics, actions to recover damages for a criminal act, and cases where the medical services were sought in an effort to commit a crime or tort. (California's statute includes the most comprehensive list of exceptions).

Recently, at least seventeen states have enacted special laws relating to psychologist-client or psychiatrist-patient communications. Because of the nature of such communications, these statutes create a much more comprehensive privilege, either placing them on the same ground as the attorney-client privilege or providing a blanket exemption from disclosure in both civil and criminal actions with few or no exceptions—the most common of which is where a defendant raises a defense of insanity. Some statutes extend this psycho-privilege to communications with members of the patient's family or members of group therapy sessions.

### Waiver

There are different ways of waiving the physician-patient privilege besides the specific statutory exceptions mentioned above. Most of these methods are derived from the case law rather than from the statutes. All of these waivers are variations of the voluntary waiver by the holder of the privilege. The reasoning behind any of these waivers is to prevent the holder of the privilege from having an unfair advantage in a lawsuit. If the holder of the privilege could selectively put on testimony and by claiming privilege prevent his opponents from countering it, the handicap would probably be too great to overcome.

In some states, the mere commencement or filing of a suit in which the patient's physical or mental condition is at issue constitutes a waiver of the privilege (e.g., New York). In others, filing is not a waiver, but the waiver is not postponed until the patient introduces testimony at trial relating to his physical condition. Instead, it is accelerated so that the opposing party may investigate the claims of the patient during the discovery process (e.g., Ohio). Some states permit depositions to be taken, including questions on privileged matters, but permit the patient to invoke the privilege later on in the suit (Michigan). But other states do not require a waiver until a physician is called as a witness and examined directly (e.g., Iowa). Whether this applies to depositions as well as trial testimony is not clear. Most states also regard a waiver of the privilege as to one physician as a waiver of the privilege for all the physicians who treated the patient (e.g., Arkansas).

Thus, the time for a waiver, as construed by the courts, ranges from the moment of filing to the time when a physician is examined directly as a witness. The competing interests of confidentiality and fairness to opposing litigants

have been reconciled differently by the state courts and the question remains open: At what point in a lawsuit to recover damages for personal injuries or malpractice should the privilege be waived?

## II. PUBLIC RECORDS ACTS

Most states have statutes requiring that public records, that is, records kept by governmental bodies, be open for public inspection (see Arkansas's "Freedom of Information Act").

Fifteen states specifically exempt medical records from the provisions of the inspection acts.

The statutes of five states merely include language generally exempting records otherwise required by law to be kept confidential (e.g., Nevada). All of these states have physician-patient privilege statutes which would seem to bring most medical records under this exception.

Some states only exempt specific types of medical information on file with government agencies such as records of patients in state or county hospitals (Tennessee and Ohio), records of patients receiving state medical assistance (Tennessee), and reports of injuries suspected to be caused by violence (Oregon). Required reports statutes also frequently contain limitations as to what persons may review them.

Over one-half of the states do not specifically exempt medical or confidential records from their open records acts.

## III. MEDICAL LIEN ACTS

Most states have hospital (and some have physicians') lien statutes which allow the hospital or doctor to assert a lien on any judgment rendered against a person liable for the injuries for which the injured person was hospitalized and thus to collect for their unpaid bills.

The hospital lien laws of thirteen jurisdictions allow the party against whom a lien has been asserted to examine the hospital records relating to the services furnished the injured person.

In three jurisdictions - Colorado, Maine and the District of Columbia, - inspection is restricted to financial records. In Maryland, inspection is permitted "to ascertain charges and estimate the lien" suggesting that inspection is actually limited to financial records. Most statutes, however, refer only to "hospital records" in general leaving open the question of what kind of records fall under the Act. Illinois' law also permits the defendant to request and receive a written statement of the nature and extent of the injuries sustained by the plaintiff, the treatment given him, and how the injuries were received (if stated by the injured person and contained in the records).

Most of the states with such lien acts either have no physician-patient privilege statute or waive it automatically in personal injury actions.

## IV. REQUIRED REPORTS

Most states require that two types of medical problems be reported to the appropriate governmental agency -

mental disease and suspected cases of child abuse.

Most of the child-abuse statutes also include provisions stating that the physician-patient privilege does not operate to exclude from evidence such reports. Usually physicians and others reporting such cases are granted immunity from civil liability for testifying and reporting.

Almost half the states which require reports of cases of mental disease protect, to a greater or lesser degree, the confidentiality of such reports. The most protective require that doctors report cases by code number only. In other states, the reports are not open to public inspection but may be seen only by specified health officials.

Many states also require physicians and hospitals to report tuberculosis and other types of contagious diseases, but the identity of patients usually is protected from public disclosure.

Other types of medical reports occasionally required are cancer, drug addiction, injuries inflicted by violence and cases of occupational disease. In the case of drug addiction, the trend is to create complete confidentiality and immunity for those who seek treatment.

## SPECIAL ACCESS LAWS

### Statutes

Only nine states have statutes specifically allowing patients or their attorneys to inspect hospital medical records. Of these, the statutes of California, Illinois and Utah permit records to be examined and copied by the patient's authorized attorney only, not by the patient himself. However, the statutes of the six other states explicitly or implicitly allow access to the patient himself (e.g., Massachusetts, New Jersey and Wisconsin). The statutes of California and Wisconsin include sanctions for refusal to disclose. Thus, California's law requires that patients be reimbursed for all legal expenses, including attorneys' fees, in any proceeding to enforce the provisions of the statute; while Wisconsin requires the custodian to pay all necessary costs of obtaining the records plus up to fifty dollars in attorneys' fees.

The statutes vary somewhat in their details. California's statutes specifically allow access prior to the filing of an action. Connecticut permits records to be examined only after the patient has been discharged. In Louisiana, a patient or his attorney is authorized to get a "full report" suggesting something less than a look at the original records. Mississippi requires a showing of "good cause." New Jersey permits access to plaintiffs and defendants in personal injury suits.

Many of these access statutes state that their provisions are inapplicable to the records of mental patients whose records are governed by separate laws and regulations.

Many states are by statute explicitly protective of the confidentiality of the records of patients in state mental institutions. Usually the disclosure of their records is prohibited by law except (1) on the consent of the patient, (2) by consent of the hospital director as necessary for the treatment of the patient, (3) as a court may direct upon

determination that disclosure is necessary for the conduct of proceedings before it and that failure to disclose would be contrary to the public interest, and (4) in hospitalization proceedings upon request of the patient's attorney (e.g., Kansas).

### Case Law

Cases directly touching on the right of access to hospital records are uncommon. A federal district court in Oklahoma has held that a patient has a property right in information in his hospital records and he, or someone authorized by him, has a right to inspect and copy those records without the necessity of resorting to litigation. The New York Supreme Court held that a hospital cannot withhold a patient's records from him when he wishes to determine, for the purposes of a malpractice claim, which doctors operated on him or treated him.

In Ohio, the Supreme Court has held that a hospital may permit a patient to see as much of his hospital records as the hospital feels is in the beneficial interest of the patient. If unsatisfied with the scope of the inspection, the patient may institute a court action to require the hospital to furnish the entire record.

### Regulations

Considering the absence of statute or case law, access to hospital records in most states is governed by regulations of state hospital licensing agencies. These regulations were difficult to obtain, but the results are sufficient to indicate the types of administrative provisions encountered.

Where a regulation makes reference to the ownership of hospital records, it generally places title to the records in the hospital. This appears to be a narrow view, the better approach being that the hospital and the patient each have an interest in the records of the patient. Few states have recognized the interest of the patient, however. In many instances, whether permitted by regulations or in the absence of any contrary regulations, individual hospitals establish policies governing access to hospital records, the vast majority of which are quite restrictive.

The regulations fall into two general categories. Some allow inspection on the written consent of the patient, with the patient, other persons (i.e., attorneys) or both being allowed to inspect the records.\* Under this type of regulation a patient or his attorney could inspect his hospital records to determine whether he should institute a lawsuit. All states permit inspection of hospital records (other than mental hospitals) upon court order, obtainable after a lawsuit has been commenced. If neither regulations nor the policies of the individual hospital, if applicable, provide for inspection by the patient presumably the filing of a lawsuit would be a prerequisite to inspection, which

\*The rationale for allowing access to the legal representative and not the patient, found in some of the access statutes and regulations and hospital practices, is that there are some medical matters which the patient may not understand or should not know in the interest of his health.



could be accomplished by resorting to state discovery procedures.

## Summary of Legal Literature

Law review articles and commentators address themselves to four areas of concern relevant to this study. These are: (1) physician-patient privilege; (2) in a malpractice action the defendant-physician's access to plaintiff-patient's prior and subsequent medical records where plaintiff has asserted physician-patient privilege; (3) possible remedies to protect the patient against unauthorized disclosure by physicians of medical secrets outside the courtroom; and (4) patient's access to his own medical records.

### PHYSICIAN-PATIENT PRIVILEGE

Professor Wigmore's scathing denunciation of the physician-patient privilege remains its definitive criticism.<sup>1</sup> His argument, which permeates the literature on the subject, is that the physician-patient privilege does not satisfy the four fundamental conditions which he deems essential to every privilege for communication, i.e., to every exception to the general requirement that every person testify as to all facts inquired of in a court of justice. These conditions are: (1) the communication must originate with the expectation of confidentiality; (2) the element of confidentiality must be essential to the satisfactory maintenance of the relationship between the communicating parties; (3) the relationship must be one which society seeks to foster; and (4) the harm from disclosure must be greater than the expected benefit to justice gained by admitting the testimony.<sup>2</sup> Professor Wigmore submits that with the exception of the third condition, none are satisfied in the physician-patient relationship.

As to the first, he argues that with the exception of loathsome diseases or abortion, few if any patients attempt to preserve any real secrecy. As to the second, he maintains that even where a patient does expect confidentiality, he would not be deterred from seeking medical assistance because of the possibility of future disclosure in court. And as to the fourth, he emphatically argues that the injury to justice is far greater than the injury to the relation.<sup>3</sup> Ninety-nine per cent of the litigation in which the privilege is invoked, he maintains, involves either personal injury cases—in which the patient has voluntarily brought himself into court and placed the extent of his injury at issue—actions on life insurance policies where the deceased allegedly misrepresented his health to the insurer, and testamentary actions where the testator's mental capacity is being questioned.<sup>4</sup> In none of these can there be any fear that the absence of the privilege would hinder people from consulting physicians freely; in all of these is the truth as to the medical questions an absolute necessity if justice is to be served.<sup>5</sup>

In short, concludes Professor Wigmore, there is little to be said in favor of the privilege and much to be said against it.<sup>6</sup>

He suggests as a modest improvement in the present law where the privilege exists, to adopt the North Carolina rule which allows the court to require disclosure when justice demands.<sup>7</sup> Another modification of the physician-patient privilege that has been proposed is to adopt the three conditions that Professor Wigmore argues are usually not met in the physician-patient relationship into a new privilege statute; when the conditions are satisfied, then the physician-patient privilege—as well as any other types of communication that meet the conditions—would apply. The proposed statute requires a case-by-case determination on the facts by the trial court as to whether the conditions have been met; it explicitly forbids consideration of case precedent concerning the type of relationship involved (e.g., physician-patient, attorney-client, etc.).<sup>8</sup> A third proposal for modification of the physician-patient privilege is to exclude it when the condition of the patient is a factor in a claim or defense at trial.<sup>9</sup> Another suggests an inference of adverse evidence when the privilege is not waived in a personal injury suit.<sup>10</sup>

The current draft of the Proposed Federal Rules of Evidence has abolished the physician-patient privilege, but does contain a psychotherapist privilege.<sup>11</sup> The advisory note to that rule states:

"The rules contain no provision for a general physician-patient privilege. While many states have by statute created the privilege, the exceptions which have been found necessary in order to obtain information required by the public interest or to avoid fraud are so numerous as to leave little if any basis for the privilege."<sup>12</sup>

In jurisdictions where the privilege does exist, it can be waived by consent, voluntary disclosure by the patient of the subject matter of the confidence, or contract.<sup>13</sup> That in personal injury litigation it is practically inevitable that the plaintiff will waive his privilege at trial by introducing evidence as to the extent of his injuries most of the authorities agreed.<sup>14</sup> Numerous commentators have suggested that such waiver be accelerated to take effect at the time of the filing of the personal injury suit so as to facilitate discovery—that is, so as to ensure the defendant a proper opportunity to prepare his defense as to the medical information.<sup>15</sup> One author has listed discovery devices to compel such waiver in personal injury suits when the privilege is being invoked as a dilatory tactic.<sup>16</sup> The question of waiver in malpractice suits is the subject of the next section of this discussion.

### DEFENDANT-PHYSICIAN'S ACCESS TO PLAINTIFF-PATIENT'S PRIOR AND SUBSEQUENT MEDICAL RECORDS IN MALPRACTICE ACTIONS WHERE PLAINTIFF HAS ASSERTED PHYSICIAN-PATIENT PRIVILEGE

Absent waiver of the physician-patient privilege, there is in a number of states no procedure assuring the malpractice defendant-physician pretrial discovery of plaintiff-patient's prior and subsequent medical history.<sup>17</sup> Without such

discovery, the defendant is clearly at a great tactical disadvantage. Indeed, a recent law review comment cites a 1971 Ohio case which held that the application of the privilege in a malpractice action is an unconstitutional denial of due process and pleading.<sup>18</sup> The comment recognizes that although some states statutorily provide for waiver in malpractice cases, others do not.<sup>19</sup>

Two cases discussed in the literature illustrate the legal issues involved here. The first is a South Dakota case discussed in some detail in the law review comment mentioned above.<sup>20</sup> The case is a malpractice action in which the defendant-physician attempted to depose the physician who treated the plaintiff subsequent to the defendant-doctor's treatment. The issue before the court was whether the plaintiff-patient had waived the physician-patient privilege when, after filing of the suit, he had released by stipulation to defendant-doctor's counsel hospital records of the patient's subsequent care. The South Dakota Supreme Court reversed a lower court ruling and held that the privilege had not been waived. The contents of the records released not being before the court, it held that the fact of a release of hospital records whose contents were unknown to the court was insufficient to establish a waiver.<sup>21</sup>

A very informative article directly on point discusses the second case, an otherwise unreported case in which the Missouri Supreme Court reached a contrary result.<sup>22</sup> There plaintiff-patient's response to defendant-physician interrogatories were unresponsive as to prior and subsequent medical treatment. A motion to compel responsive answers was overruled. Defendant-physician then filed a motion for *subpoena duces tecum* of the prior physician; the plaintiff resisted on the grounds of privilege. The trial court sustained the motion, holding that a physician defendant to a malpractice action is entitled to discovery of medical facts by deposing both prior and subsequent treating physicians, despite the assertion of physician-patient privilege without statutory or contractual waiver. The Supreme Court declined to issue even a preliminary writ prohibiting discovery.<sup>23</sup>

The article in which this case is reported considers the need for such discovery and cites several factual bases upon which courts have allowed discovery either on the theory that the privilege has been waived, or despite the privilege because of the need to prepare for trial and eminent fairness.<sup>24</sup>

## POSSIBLE REMEDIES TO PROTECT THE PATIENT AGAINST PHYSICIAN'S UNAUTHORIZED DISCLOSURE OF MEDICAL SECRETS OUTSIDE THE COURTROOM

"Legislatures and courts have been occupied for over a century in closing the physician's mouth in the very place where the truth is badly needed (i.e., the courtroom). And yet the much more important obligation of his silence in private life has hardly been considered. In the few instances where honest patients do

dread disclosure of their physical condition by a doctor, their fear is not that the truth may some day be forced out of him in a court, but that he may voluntarily spread the fact among his friends and theirs in conversation. Yet against this really dangerous possibility the statutes and the courts give almost no protection."<sup>25</sup>

Physician licensing statutes provide the only possibility of statutory sanctions against such unauthorized disclosure. A doctor's conduct in this respect may be found to make him unfit to hold a license, but such concept affords no remedy to the patient. A number of commentators have attempted to grapple with the challenge that Professor Chafee raises in the above quotation.

In one,<sup>26</sup> the author first considers possible remedies under existing theories of recovery. First he raises breach of contract. In the express or implied contract of employment between physician and patient, the author proposes the existence of an implied term of secrecy arising from the medical profession's code of ethics. This remedy, however, has received little attention, he points out, because of the difficulty in establishing contract damages in such a setting, and the even greater difficulty in gaining recovery for mental distress from a contracts remedy.<sup>27</sup>

The author quickly dismisses defamation, since it is subject to the defense of truth.<sup>28</sup>

Breach of privacy, a relatively new tort, is next considered.<sup>29</sup> The author points out that the tort has been divided into four classes, the first of which—disclosure of private facts—could encompass a physician's breach of secrecy.<sup>30</sup> However, courts have unfailingly held to a requirement of wide publicity before the disclosure is actionable; hence, concludes the author, the remedy has a limited effectiveness.<sup>31</sup>

The author next proposes a new tort—a fifth class under breach of privacy—called "breach of confidence." He argues that public policy reflected in privileged communications statutes, physician licensing statutes providing for loss of license upon breach of secrecy, and the medical profession's code of ethics all provide a framework for recognizing a cause of action for breach of confidence. The new tort would be a "recognition of the special characteristics of secrecy in the physician-patient privilege." It would be subject to the affirmative defense of justification, in three forms: (1) consent; (2) compulsion of the law, as in required reports of venereal disease; and (3) general public health and welfare, where some type of duty is owed to the public, e.g., a duty to protect the lives of future airline passengers when a doctor discovers a pilot's poor vision—that supersedes the duty of privacy.

The author concludes by suggesting that although the courts could extend a remedy to the patient for breach of confidence simply by acquiescing in the public policy in its favor, the new tort should be statutorily created, thus avoiding an inconsistent body of interpretive case law that would leave the physician in a constant state of uncertainty until a uniform standard was adopted. Damages should be recoverable for both pecuniary loss and mental dis-

ness. The original burden of proof should lie with the patient, but upon such proof the burden of the affirmative defense of justification should rest with the physician. "Such a statute," the author concludes, "would be the most consistent and clearly defined means of providing both recovery for the patient and a guideline for the physician."<sup>32</sup>

A note in the *Denver Law Review* provides a clear and comprehensive treatment of this subject, including brief summaries of recent cases on point. The article concludes that recovery grounded in malpractice because the unauthorized disclosure constitutes professional conduct falling below the prevailing professional standard of care and thus is malpractice may be the most sensible approach.<sup>33</sup>

The principles of this subsection would also be applicable where medical personnel disclose information concerning one patient in order to defend or prosecute another patient's malpractice action, e.g., where that information is sought to be used to establish the customary or non-customary nature of a certain course of treatment or to impeach the non-plaintiff patient's testimony if he appears as a witness. They would also be applicable to records of

the plaintiff-patient insofar as he is not seeking the records himself and has not waived the protection by bringing suit (see privilege *supra*).

## PATIENT'S ACCESS TO HIS OWN MEDICAL RECORDS

The literature on this issue is sparse. A comprehensive search of all periodical literature from the present through 1965 reveals only one article on point.<sup>34</sup> An Ohio case there cited<sup>35</sup> held that since hospital records are essential to proper administration, they are the property of the hospital; however, the patient has a property right in the information contained in the report.<sup>36</sup> The plaintiff-patient had sought a mandatory injunction compelling the defendant hospital to allow her to examine her medical records with a view toward a suit against a third party; the injunction was granted. In accord, and also discussed in the article, is a leading Oklahoma case.<sup>37</sup> The author there concludes from these two cases that such is the state of the law.<sup>38</sup>

1. Wigmore, *Evidence* § 2380a (McNaughten rev. 1961) [hereinafter cited as Wigmore.]

2. Wigmore § 2285.

3. Wigmore § 2380a.

4. As to attempts to assert the privilege in medical malpractice action, see part (2) of this text.

5. Wigmore § 2380a.

6. *Id.* § 2380a; see also Baldwin, *Confidentiality Between Physician and Patient*, 22 Md.L.Rev. 181 (1962); Chafee, *Privileged Communications—Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand?* 52 Yale L.J. 607 (1943); Morgan, *Suggested Remedy for Obstructions to Equal Testimony by Rules of Evidence*, 10 Ch.L.Rev. 285 (1943).

7. Wigmore § 2380a; see also Comment, *Waiver of Physician-Patient Privilege*, 24 Wash. & Lee L.Rev. 151, 157 (1967); but see Comment, *Waiver of Physician Patient Privilege*, 51 Minn. L.Rev. 575, 581 (1967).

8. Comment, *Privileged Communications—A Case-by-Case Approach*, 23 Maine L.Rev. 443 (1971).

9. Comment, *The Physician-Patient Privilege—Alternatives to the Rule as it now Exists in Oklahoma*, 24 Okla. L.Rev. 380 (1971).

10. Sawyer, *Physician-Patient Privilege—Some Reflections*, 14 Drake L.Rev. 83 (1965).

11. October 1971 draft of Proposed Federal Rules of Evidence for the United States District Courts and Magistrates, Rule 504.

12. *Id.*, Advisory Notes to Rule 504.

13. See Comment, *Waiver of the Physician-Patient Privilege*, 46 Chi-Kent L.Rev. 37 (1969); Stewart, *Waiver of the Physician-Patient Privilege in Personal Injury Litigation*, 2 Forum 16 (1966).

14. But See Comment, *Physician-Patient Privilege in Oklahoma*, 7 Tulsa L.J. 157 (1971); Comment, *Waiver of Physician-Patient Privilege*, 51 Minn. L.Rev. 575, 579 (1967).

15. See Comment, *Physician-Patient Privilege in Oklahoma*, 7 Tulsa L.J. 157 (1971); Comment, *Waiver of Physician-Patient Privilege*, 24 Wash. & Lee L.Rev. 151 (1967); Copple, *Physician-Patient Privilege—A Need to Revise the Arizona Law*, 6 Ariz. L.Rev. 292 (1965), but see Comment, *Waiver*, *supra* note 14.

16. Note, *Accelerated Waiver of the Physician-Patient Privilege*, 42 Wash. L.Rev. 1107 (1967); see also Hogan, *Waiver of Physician Patient Privilege in Personal Injury Litigation*, 52 Marq. L.Rev. 75 (1968).

17. Havener, *Malpractice Medical Discovery v. Physician-Patient Privilege—Something's Got to Give*, 35 Ins. Couns.-J. 41 (1968).

18. Comment, *Patient-Physician Privilege in the Discovery Process*, 17 So. Dak. L.Rev. 188, 193. The case cited is *Otto v. Miami Valley Hosp. Soc. of Dayton, Ohio, Inc.*, 266 N.E.2d 270, 272 (Ohio C.P. 1971).

19. *Id.* at 193.

20. *Id.* at 188, 189. The case is *Hague v. Massa*, 80 S.D. 319, 123 N.W.2d 131 (1963).

21. *Id.* at 189.

22. *State ex. rel. Hedrick v. Stewart*, Sup. Ct. Docket No. 27197, Sept. Session, 1964, petition for prohibition denied Dec. 14, 1964, reported in Havener, *supra*, at 42.

23. *Id.*

24. Havener, *supra* note 17, at 42 cf. the comprehensive review of the law in Urbom, *Medical Discovery in the Fifty States Plus Two*, 33 Ins. Couns. J. 41 (1968).

25. Chafee, *Privileged Communications - Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand?* *supra* note 6 at 617, see also Baldwin *supra* note 6; but see Comment, *Legal Protection of the Confidential Nature of the Physician-Patient Relationship*, 52 Colum. L.Rev. 383, 398 (1952).

26. Roedersheimer, *Action for Breach of Medical Secrecy Outside the Courtroom*, 36 U. Cinc. L.Rev. 103 (1966).

27. *Id.*

28. *Id.*

29. See Warren and Brandeis, *The Right to Privacy*, 4 Harv. L.Rev. 193 (1890).

30. See W. Prosser, *Law of Torts* §117 (1971).

31. For a fuller discussion of possible existing remedies, see Note, *Extra Judicial Truthful Disclosure of Medical Confidences - A Physician's Civil Liability*, 44 Denver L.J. 463 (1967).

32. Roedersheimer, *supra* note 27.

33. Note, *Extra Judicial Truthful Disclosure*, *supra* note 32; see also 79 Harv. L.Rev. 1723 (1966); 11 Vill. L.Rev. 662 (1966).

34. Fleisher, *Ownership of Hospital Records and Roentgenograms*, 4 Ill. Continuing Legal Ed. 73 (1966).

35. *Wallace v. University Hospitals of Cleveland*, 82 Ohio Law Abstract 224, 164 N.E.2d 917, 918 (1959), cited in Fleisher, *supra* note 35.

36. As a practical matter this property right constitutes a right to inspect and copy.

37. *Pyramid Life Ins. Co. v. Masonic Hospital Ass'n*, 191 F.Supp. 51 (W.D. Okla 1961), cited in Fleisher, *supra* note 35.

38. Fleisher, *supra* note 35, at 75, 77.



## Selected Legal Bibliography

The following is a list of relevant law review material found dating from the present through 1966, with selected earlier material.

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- Apple, *Preparing the Medical Aspects of Personal Injury Suits*, 37 Okla. Bar Assoc. J. 1669 (1966)
- Baldwin, *Confidentiality between Physician and Patient*, 22 Md. L.Rev. 181 (1962)
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- Copple, *Physician-Patient Privilege: A Need to Reform the Arizona Law*, 6 Ariz. L.Rev. 292 (1965)
- Fleisher, *Ownership of Hospital Records and Roentgenograms*, 4 Ill. Continuing Legal Ed. 73 (1966)
- Freeman, *Significant Changes in Two Decades of Hospital-Doctor-Patient Relation*, 617 Tr. L. Q. 34 (1969-70)
- Havener, *Malpractice Medical Discovery v. Physician Patient Privilege—Something's Got to Give*, 35 Ins. Couns. J. 41 (1968)
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- Sagal, *Physician's Medical Report*, 8 Trial 59 (1972)
- Sawyer, *Physician Patient Privilege—Some Reflections*, 14 Drake L.R. 83 (1965)
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### COMMENTS AND NOTES

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- Comment, *Patient Physician Privilege in the Discovery Process*, 17 So. Dak. L.Rev. 188 (1972)

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- Physician-Patient Privilege in Oklahoma*, 7 Tulsa L.J. 157 (1971)
- Comment, *Privileged Communications—A Case by Case Approach*, 23 Maine L.R. 443 (1971)
- Comment, *Waiver of Physician-Patient Privilege*, 51 Minn. L.Rev. 575 (1967)
- Comment, *Waiver of Physician-Patient Privilege*, 24 Wash. & Lee L.Rev. 151 (1967)
- Comment, *Waiver of the Physician-Patient Privilege in Missouri*, 34 Mo. L.Rev. 397 (1969)

### LAW REVIEW CASE REPORTS

- 79 Harv. L.Rev. 1723 (1966)
- 11 Vill. L.Rev. 662 (1966)
- See also Hayt, Hayt & Groeschel *Law of Hospital, Physician and Patient*. (2d Ed., Hospital Textbook Co., N.Y. 1952); Univ. of Pitts., *Hospital Law Manual* (Aspen Systems, Inc.)

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- , *The Quest for Hospital Records*, 45 Infirmiere 100 (Oct. 1971)
- Dornette, *Medical Records*, 8 Clin. Anesth. 285 (1972)
- , *The Physician-Patient Relationship*, 8 Clin. Anesth. 213 (1972)
- Hagman, *The Non-litigant Patient's Right to Medical Records—Medicine v. Law*, 14 J. Forensic Sci. 352 (July 1969)
- Ederma, *Confidentiality of Medical Records and Invasion of Privacy*, 11 J. Occup. Med. 200 (April 1969)
- Horty, *Court's Need Can Impose Limits on Physician-Patient Privilege*, 113 Mod. Hosp. 54 (August 1969)
- , *Medical Records Aren't Fishing Grounds*, 116 Mod. Hosp. 68 (March 1971)
- , *Only Patient Can Permit Examination of his Record*, 117 Mod. Hosp. 71 (September 1971)
- Physician and Hospital Record Retention and Inspection*, 68 Wisc. Med. J. 38 (Jan. 1969)
- Wren, *Protecting the Patient's Right to Privacy*, 47 Hosp. Top. 49 (February 1969)

## Suggestions for Further Study

The question pertinent to malpractice actions about which the law is largely silent or ambiguous is the issue of the patient's right to see his own medical record, particularly without first commencing litigation. The nine state

statutes specifically relating to the issue are permissive, and assert the patient's right without placing restrictions on it.

We conclude, therefore, that the most serious impediment to obtaining access to hospital records can be the policies of individual hospitals against disclosure. Further investigation of these informal practices would be invaluable.

In the absence of a statute, decision, or regulation specifically granting access, a hospital policy against disclosure can be the major obstacle confronting a person trying to inspect his hospital records.

Automated central record computers are a possible source of medical information. These ought to be investigated with respect to access. Who supplies information and who may get it? What regulation is there of this function? (See, for an introduction to the area, Springer, *Automated Medical Records and the Law* (1971)).

No attempt has been made to study the doctor's ethical duties respecting disclosure nor the problem of in-house and scientific or disciplinary use of a patient's records. Also beyond the scope of the current study was law enforcement, Workmen's Compensation, various public welfare and Social Security programs, and public employment.

## State-by-State Study

This study summarizes the law of each state under five headings: physician-patient privilege, public record acts, medical lien acts, required reports, special access laws. Each heading may have three sub-headings: Statute, case-law, regulations. Where a heading or sub-heading is omitted in the summary of any state, that state's law is silent on that heading or sub-heading.

### ALABAMA

#### Physician-Patient Privilege

Statute: Alabama has a statutory psychologist-client privilege which is placed on the same basis as the attorney-client privilege.<sup>1</sup>

#### Required Reports

Statute: Physicians are required to file reports of cases of venereal disease.<sup>2</sup> By a separate statute these reports are made confidential.<sup>3</sup>

#### Special Access Laws

Regulations: The questions of confidentiality and disclosure of medical records in Alabama is addressed through administrative regulations established by the Alabama State Board of Health, which provides that patients' records are confidential. Access to the records is determined by the hospital governing board.

Inspectors for licensure or surveyors for membership in professional organizations have a limited right to review records.<sup>4</sup> The regulations provide for monthly review and analysis of the clinical experience of the medical staff, using the patients' medical records as the basis for such review.<sup>5</sup> Title to the records is vested in the hospital, and control rests with the hospital administrator.<sup>6</sup> The regulation on storage and safety of records states that records are to be handled in such a manner as to safeguard them from unauthorized use. *Mental patients*: The State Mental Health Board has the power to set standards for the transfer of patients and their records. ALA. CODE tit. 22 §320(11) (Supp. 1969). The board of trustees of hospitals for the insane has access to the books and records of the hospital at any time. ALA. CODE tit. 45 § 203 (1958).

<sup>1</sup> ALA. CODE tit. 46, § 297(36) (Supp. 1969)

<sup>2</sup> ALA. CODE tit. 22, § 262, 267 (1958)

<sup>3</sup> ALA. CODE tit. 22, § 269 (1958)

<sup>4</sup> Alabama State Board of Health, Rules, Regulations and Standards: § 701.8 (1970)

<sup>5</sup> *Id.* § 502.1(4)

<sup>6</sup> *Id.* § 701.4

<sup>7</sup> *Id.* § 701.2

### ALASKA

#### Physician-Patient Privilege

Statute: Physician or surgeon may not, against the objection of his patient, be examined in a civil action or proceeding as to any information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient.<sup>1</sup> This privilege does not apply in cases concerning child abuse.<sup>2</sup>

Case Law: Plaintiffs in personal injury actions waive privilege by commencement of the action to the extent that attending physicians may be required to testify on pretrial deposition with respect to injuries sued upon.<sup>3</sup>

#### Public Record Acts

Statute: Statute granting right of public inspection lists exception for medical and related public health records.<sup>4</sup>

#### Special Access Laws

Statute: Records of mental patients may only be disclosed as (1) the individual consents, or (2) as a court directs if necessary for the conduct of proceedings before it and non-disclosure would be contrary to the public interest.<sup>5</sup>

<sup>1</sup> ALAS. R.CIV. P.43(h)4 (Supp. 1968)

<sup>2</sup> ALAS. R.CIV. P.43(h)8 (Supp. 1968)

<sup>3</sup> Mathis v. Hilderbrand, 416 P.2d 8, 10 (Alas. 1966)

<sup>4</sup> ALASKA STAT. § 09.25.120(3) (1962)

<sup>5</sup> ALASKA STAT. § 47.30.260 (1962)

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## ARIZONA

## Physician-Patient Privilege

**Statute:** In a civil action, a physician or surgeon may not, without the consent of his patient, be examined as to communications or knowledge obtained in examination of the patient.<sup>1</sup> Privilege is waived if the person voluntarily testifies as to such communications.<sup>2</sup>

In criminal actions a physician may not be examined as to any information acquired in attending the patient which was necessary to enable him to treat the patient.<sup>3</sup>

Unprofessional conduct includes willful betrayal of a professional secret or willful violation of a privileged communicational except as required by law.<sup>4</sup>

**Case Law:** Privilege as an objection applies to questions put to plaintiff at deposition.<sup>5</sup>

## Public Record Acts

**Statute:** Information in vital records is not to be disclosed.<sup>6</sup>

## Special Access Laws

**Regulations:** State regulation regarding clinical records is silent as to accessibility.

**Other:** According to Arizona Hospital Association "Consent Manual" hospital records are the property of the hospital and may only be released to various classes of "interested persons" including patient's attorney when authorized in writing, patient's insurance company, but only directly to patient upon the consent of the administrator or attending physician. When attorney employed by the patient requests information "his reason for such request should first be determined." Although not a legal necessity, the hospital may, as a matter of policy, call for the consent of attending physicians.<sup>8</sup>

<sup>1</sup> ARIZ. REV. STAT. § 12-2235 (1956).

<sup>2</sup> ARIZ. REV. STAT. § 12-2236 (1956).

<sup>3</sup> ARIZ. REV. STAT. § 13-1802 (Supp. 1971).

<sup>4</sup> ARIZ. REV. STAT. § 32-1404(10)(b) (Supp. 1971).

<sup>5</sup> *Patania v. Silverstone*, 3 Ariz. App. 424, 415 P.2d 139, 144 (1966).

<sup>6</sup> ARIZ. REV. STAT. § 36-339 (Supp. 1971).

<sup>7</sup> Arizona Department of Health, Rules and Regulations for the Licensing of Hospitals, Reg. 4-2-4.1.

<sup>8</sup> Arizona Hosp. Ass'n. Consent Manual, ch. 19 (1969).

June 12, 1972

Mr. Peter B. Stein  
Task Force on Medical Malpractice  
Georgetown University Law Center  
Washington, D.C. 20001

Dear Mr. Stein:

This is in response to your letter of June 6, 1972 requesting information regarding statutes, regulations and practices relating to access to hospital and medical records in Arizona.

Enclosed is a copy of Article 7, Chapter 13, Title 12, Arizona Revised Statutes. These Sections are the only provisions of Arizona law relating to obtaining records which are specifically applicable to hospital records. Enclosed also is a copy of Arizona State Department of Health Regulations for the Licensure of Hospitals which contains Regulation 4-2-4.1 (mentioned in your letter). As may be seen, this regulation does not provide any very helpful guidance regarding access to these records. I am also enclosing a copy of Chapter 19 of the Arizona Hospital Association "Consent Manual". This material was prepared in 1967 and, therefore, does not necessarily reflect the provisions of the hospital records statutes mentioned above. However, I am advised that from the pragmatic standpoint the material in Chapter 19 is pretty closely adhered to by hospitals in Arizona.

With respect to the three questions in your letter, it would appear that access to hospital and medical records may be had (1) by this Department as the licensing agency without consent; (2) by a physician on the assurance that he is the physician of the patient whose records are sought; and (3) by other persons with the consent of the patient. If the custodian of the record is reluctant to provide the record upon request, the applicant may, of course, be forced to obtain a subpoena. Question 2 is covered above. In answer to question 3, a person giving consent must be competent and, if not the patient, must be a legal guardian or otherwise authorized to give consent to access. [ . . . ]

Very truly yours,

WJW:me  
Enclosures 3

William J. White, Director  
Management Advisory Services  
Division

## ARKANSAS

## Physician-Patient Privilege

**Statute:** Arkansas has a privileged communications statute which applies to physicians, surgeons and trained nurses, making them incompetent witnesses as to information acquired from the patient while attending him in a professional character and which was necessary to treat him.<sup>1</sup> There is a separate statutory privilege for communications between psychologist and client, which privilege is placed on the same basis as that between attorney and client.<sup>2</sup>

**Case Law:** While it was apparently assumed that this privilege applies in criminal as well as civil

actions, the statute was only recently construed as applicable to criminal proceedings.<sup>3</sup> *Waiver of privilege*: Arkansas has rejected the view taken by some states that the filing and maintenance of an action to recover for physical injuries in itself constitutes a waiver of the physician-patient privilege so as to require testimony of attending physicians on pretrial deposition or disclosure of medical records and information. *Bower v. Murphy*, 247 Ark. 238, 444 S.W.2d 883 (1969). On this issue the court relied on earlier Arkansas cases, stating that discovery and pretrial statutes were not in such conflict with those decisions as to require a departure from the rules therein stated. See *Maryland Casualty v. Maloney*, 119 Ark. 434, 178 S.W. 387 (1915) and *American Republic Life Ins. Co. v. Edenfield*, 228 Ark. 93, 306 S.W.2d. 321 (1957). However, the court went on to hold that the trial court may require the plaintiff-patient to state whether or not he intends to rely on or waive the physician-patient privilege. If the privilege will be waived and medical evidence offered at trial, such evidence may be discovered by the defendant. *Records available for research*: An Arkansas statute provides that records of certain medical societies and hospital committees are available for medical research only and are strictly confidential. ARK. STAT. ANN. 82-357, 358 (Supp. 1971).

#### Public Record Acts

Statute: Medical records are specifically exempted from the Freedom of Information Act.<sup>4</sup>

#### Special Access Laws

Regulations: The rules and regulations for hospitals in Arkansas make medical records confidential material. Only personnel authorized by the hospital administrator have access to the records, with the exception of personnel of the State Board of Health, to whom the records are available.<sup>5</sup> Although the records are confidential, the written consent of the patient or his legal guardian is authority for disclosure of medical information.<sup>6</sup> Medical records are to be removed from the hospital environment only upon the issuance of a subpoena by a court of competent jurisdiction.<sup>7</sup>

## CALIFORNIA

### Physician-Patient Privilege

Statute: California's comprehensive statute<sup>1</sup> protects confidential communications between authorized, or reasonably believed by patient to be authorized, physician<sup>2</sup> and a person who consults him for diagnosis or treatment for a physical, mental or emotional condition.<sup>3</sup> The privilege is held by the patient, his guardian or personal representative if the patient is dead.<sup>4</sup> The privilege may be waived by the patient.<sup>5</sup> There are statutory exceptions for (1) where the patient or a party claiming through him puts his condition in issue,<sup>6</sup> (2) if the physician's services were sought in an effort to commit a crime or tort,<sup>7</sup> (3) in criminal proceedings,<sup>8</sup> (4) in a proceeding to recover damages from criminal conduct,<sup>9</sup> (5) where all parties are claiming through a deceased patient,<sup>10</sup> (6) where at issue is a question of breach of duty arising out of physician-patient relationship,<sup>11</sup> (7) in an action testing the validity of a will,<sup>12</sup> (8) in a commitment proceeding,<sup>13</sup> (9) or one to establish competence,<sup>14</sup> (10) as to information required to be reported,<sup>15</sup> (11) in an administrative proceeding to terminate a right or license.<sup>16</sup> Psychotherapist-patient communications are also privileged,<sup>17</sup> with a similar range of exceptions,<sup>18</sup> except in criminal proceedings unless the psychotherapist is court appointed.<sup>19</sup>

Eavesdropping on a conversation between, among others, a person and his physician is a felony.<sup>20</sup>

Willful betrayal of a professional secret is unprofessional conduct, but the privilege does not apply to physician licensing proceedings.<sup>21</sup>

Case Law: Section relating to confidential communication between physician and patient must be liberally construed in favor of patient.<sup>22</sup>

Requiring doctor and hospital in malpractice action to disclose names and addresses of patients who had received same type of tests was violation of privilege, especially with respect to two patients who had developed complications from such testing.<sup>23</sup>

Where the plaintiff tendered issue of her mental and emotional condition by seeking recovery of expenses for psychiatric care, there existed no testimonial privilege which would permit plaintiff's psychiatrist to refuse to answer questions at the taking of his deposition.<sup>24</sup>

#### Public Records Acts

Statute: Medical files, the disclosure of which would constitute an unwarranted invasion of personal privacy are exempted from the right of public inspection.<sup>25</sup>

<sup>1</sup> ARK. STAT. ANN. § 28-607 (1962)

<sup>2</sup> ARK. STAT. ANN. § 72-1516 (1957)

<sup>3</sup> *Ragsdale v. State*, 245 Ark. 299, 432 S.W.2d. 11 (1968)

<sup>4</sup> ARK. STAT. ANN. § 12-2804 (1968)

<sup>5</sup> Arkansas Department of Health, Rules and Regulations for Hospitals and Related Institutions (1969)

<sup>6</sup> *Id.*, §1(D).

<sup>7</sup> *Id.*, §1(E).

## Required Reports

Statutes: Physician-patient privilege statute includes exception for required reports.<sup>26</sup> These include injuries due to violence,<sup>27</sup> non-accidental injuries to children,<sup>28</sup> and communicable diseases.<sup>29</sup> Venereal disease reports to local health departments are confidential and health officers, receiving a subpoena for such a record, may assert a privilege.<sup>30</sup>

## Special Access Laws

Statute: Medical records are to be made available to a patient's attorney upon written authorization prior to filing of any action. Failure to make records available within five days may subject the person having custody or control of the records of liability for legal expenses, including attorney's fees, incurred in any proceeding to enforce the section.<sup>31</sup>

This statute does not apply<sup>32</sup> to the statute making records of mental patients confidential.<sup>33</sup>

## COLORADO

### Physician-Patient Privilege

Statute: Physicians and surgeons may not be examined without patient's consent as to any information acquired in attending patient necessary to enable him to prescribe or act for patient, but there is no privilege where physician is used by or on behalf of a patient.<sup>1</sup>

Privilege applies to psychologists, their secretaries and persons participating in group therapy sessions.<sup>2</sup>

Privilege is waived if party offers himself or physician as a witness.

Privilege does not apply to physicians or psychiatrists directed by the court to examine criminal defendants; but any information acquired, including confessions and admissions, is admissible only on the issue of insanity.<sup>4</sup>

Case Law: Once plaintiff raised issue of his physical condition by introducing testimony of two doctors as to the seriousness of his injury, he waived physician-patient privilege as to all physicians consulted.<sup>5</sup>

### Public Records Acts

Statute: Right of inspection of public records is denied as to medical, psychological, sociological and scholastic achievement data on individual persons.<sup>6</sup>

### Medical Lien Acts

Statute: Person against whom lien is asserted is permitted to examine the financial records of the hospital in reference to the services furnished for which the hospital asserts a lien.<sup>7</sup>

### Required Reports

Statutes: Physicians must report suspected cases of child abuse<sup>8</sup> to which privilege does not apply.<sup>9</sup> Reports of venereal disease are not required to include names except, where necessary, to health officer, spouse, fiancé(e) or parent.<sup>10</sup> Cases of tuberculosis are also required to be reported.<sup>11</sup>

### Special Access Laws

Regulations: State regulations pertaining to hospital records are silent as to release of information; but they do state that legal counsel should be obtained prior to disposition of medical records.<sup>12</sup> Other: Health Department Legal Counsel has stated "Patient's consent plus release from physician involved would probably gain access to any medical record as a matter of practical application."<sup>13</sup>

<sup>1</sup>CAL. EVID. CODE §§ 990-1007 (West 1966).

<sup>2</sup>CAL. EVID. CODE § 990 (West 1966).

<sup>3</sup>CAL. EVID. CODE § 991 (West 1966).

<sup>4</sup>CAL. EVID. CODE § 993 (West 1966).

<sup>5</sup>CAL. EVID. CODE § 994 (West 1966).

<sup>6</sup>CAL. EVID. CODE § 996 (West 1966).

<sup>7</sup>CAL. EVID. CODE § 997 (West 1966).

<sup>8</sup>CAL. EVID. CODE § 998 (West 1966).

<sup>9</sup>CAL. EVID. CODE § 999 (West 1966).

<sup>10</sup>CAL. EVID. CODE § 1000 (West 1966).

<sup>11</sup>CAL. EVID. CODE § 1001 (West 1966).

<sup>12</sup>CAL. EVID. CODE § 1002 (West 1966).

<sup>13</sup>CAL. EVID. CODE § 1004 (West 1966).

<sup>14</sup>CAL. EVID. CODE § 1005 (West 1966).

<sup>15</sup>CAL. EVID. CODE § 1006 (West 1966).

<sup>16</sup>CAL. EVID. CODE § 1007 (West 1966).

<sup>17</sup>CAL. EVID. CODE §§ 1010-21 (West 1966).

<sup>18</sup>CAL. EVID. CODE §§ 1016-21 (West 1966).

<sup>19</sup>CAL. EVID. CODE § 1017 (West 1966).

<sup>20</sup>CAL. EVID. CODE § 636 (West 1966).

<sup>21</sup>CAL. BUS. & PROF. CODE § 2379 (West Supp. 1971).

<sup>22</sup>Carlton v. Superior Court, 67 Cal. Rptr. 568, 261 Cal. App.2d 282, cert. denied, 68 Cal. Rptr. 469, 261 Cal. App.2d 282 (1968). Newell v. Newell, 146 Cal. App.2d 166, 303 P.2d 839 (1956).

<sup>23</sup>Marcus v. Superior Court, 95 Cal. Rptr. 545, 18 Cal. App.2d 22 (1971).

<sup>24</sup>Hall v. Superior Court, 97 Cal. Rptr. 879 (1971).

<sup>25</sup>CAL. GOV'T CODE § 6254(c) (West Supp. 1971).

<sup>26</sup>CAL. EVID. CODE § 1006 (West 1966).

<sup>27</sup>CAL. PENAL CODE § 11160 (West Supp. 1972).

<sup>28</sup>CAL. PENAL CODE § 11161.5 (West Supp. 1972).

<sup>29</sup>CAL. HEALTH & SAFETY CODE § 3125 (West 1970).

<sup>30</sup>CAL. EVID. CODE § 1040 (West 1966); 53 CAL. OP. ATTY GEN. 10 (1970).

<sup>31</sup>CAL. EVID. CODE § 1158 (West Supp. 1972).

<sup>32</sup>53 CAL. OP. ATTY GEN. 151 (1970).

<sup>33</sup>CAL. WELF. & INST'NS CODE § 5328 (West Supp. 1972).

<sup>1</sup>COLO. REV. STAT. ANN. § 154-1-7(5) (1963).

<sup>2</sup>COLO. REV. STAT. ANN. § 154-1-7(8) (Supp. 1967).

<sup>3</sup>COLO. REV. STAT. ANN. § 154-1-8 (1963).

<sup>4</sup>COLO. REV. STAT. ANN. §39-8-2(3)(b) (1963).

<sup>5</sup>Kelley v. Holmes, 28 Colo. App. 79, 470 P.2d 590, 592 (1970).

<sup>6</sup>COLO. REV. STAT. ANN. § 113-2-4(3)(b) (Supp. 1969).

<sup>7</sup>COLO. REV. STAT. ANN. § 86-8-4 (Supp. 1967).

<sup>8</sup>COLO. REV. STAT. ANN. § 22-10-2 (Supp. 1969).

<sup>9</sup>COLO. REV. STAT. ANN. § 22-10-5 (Supp. 1969).

<sup>10</sup>COLO. REV. STAT. ANN. § 66-9-2 (Supp. 1967).

<sup>11</sup>COLO. REV. STAT. ANN. § 66-12-2 (Supp. 1967).

<sup>12</sup>Colorado Dept. of Health, "Hospital and Health Facility Standards," ch. IV, § 4.2.

<sup>13</sup>Letter from David F. Foster, Legal Counsel, Colorado Department of Health to the Task Force, June 8, 1972.

## CONNECTICUT

### Physician-Patient Privilege

Statute: There is no physician-patient privilege in Connecticut. However, such a privilege does exist in the special case of persons who consult psychotherapists. In 1969, the legislature enacted a psychologist-patient privilege<sup>1</sup>. In the same year the existing provisions dealing with the psychiatrist-patient privilege were rewritten<sup>2</sup>. The law now forbids disclosure of (defined) communications between psychiatrist and patient, where the patient is identifiable, to any person, corporation or government agency without the consent of the patient or his authorized representative. However, consent of the patient is not required for disclosure of records in the following situations:

1. where disclosure is to other persons engaged in the treatment of the patient.
2. when the psychiatrist determines that there is substantial risk of imminent physical injury by the patient to himself or to others or when a psychiatrist finds disclosure necessary for the purpose of placing the patient in a mental health facility.
3. where an individual or agency is attempting to collect fees for psychiatric services (only name, address and fees may be disclosed).
4. where records have been made by a psychiatrist in the course of a court-ordered psychiatric examination, subject to certain restrictions.
5. where, in a civil proceeding, the patient has introduced his mental condition as an element of his claim or defense and the court feels that disclosure is necessary in the interests of justice.

The statutes dealing with the psychiatrist-patient privilege also provide for access to records by persons engaged in research. Any person aggrieved by a violation of these provisions may petition the proper courts for appropriate relief, including injunctions, and may maintain a civil cause of action for damages.

### Public Record Acts

Statute: Medical records are specifically exempted from the statutory provisions granting access to

public records to state residents.<sup>3</sup> Information received by the State Department of Health through filed reports, etc., shall not be disclosed publicly so as to identify individuals or institutions except in a licensure proceeding.<sup>4</sup>

### Required Reports

Statutes: Physicians must file reports of cases of occupational disease to the State Department of Health.<sup>5</sup> Physicians must also file reports of drug dependent persons, which reports will be kept confidential.<sup>6</sup>

### Special Access Laws

Statutes: Connecticut is one of the few states whose statutes expressly give the patient, his doctor, or his authorized representative the right to examine the hospital record under certain conditions.<sup>7</sup> The statute applies to public and private hospitals, and requires the hospital, upon demand of the patient, after discharge, to permit the patient, his physician or his authorized attorney to examine the hospital record, including the history, bedside notes, charts, pictures, and plates. Copies may be made. A subsequent statute sets forth the procedure to be followed where the right to inspect the records is denied.<sup>8</sup>

Case Law: A 1940 case held that in a personal injury action, defendant's motion that the court require the plaintiff to authorize the defendant's physician to inspect certain records was required to be denied, where it was not alleged and did not appear that the records sought to be examined were in the knowledge, power or possession of the plaintiff. It was not clear whether this holding has any meaning in light of the statutes discussed in this section.<sup>9</sup>

<sup>1</sup>CONN. GEN. STAT. ANN. § 52-146c (Supp. 1972).

<sup>2</sup>CONN. GEN. STAT. ANN. § 52-146d to j (Supp. 1972).

<sup>3</sup>CONN. GEN. STAT. ANN. § 1-19 (Supp. 1972).

<sup>4</sup>CONN. GEN. STAT. ANN. § 19-39 (1969).

<sup>5</sup>CONN. GEN. STAT. ANN. § 19-48 (1969).

<sup>6</sup>CONN. GEN. STAT. ANN. § 19-48a (1969).

<sup>7</sup>CONN. GEN. STAT. ANN. § 4-104 (1969).

<sup>8</sup>CONN. GEN. STAT. ANN. § 4-105 (1969).

<sup>9</sup>Byscynski v. McCarthy Freight System, 9 Conn. Supp. 44 (1940).

## DELAWARE

### Physician-Patient Privilege

Statute: In 1962, Delaware enacted a statutory psychologist-client privilege, which is the same as the attorney-client privilege.<sup>1</sup> Although no statutory physician-patient privilege is to be found in the Delaware Code, miscellaneous statutes refer to a general privilege of confidentiality.<sup>2</sup>



## Medical Lien Acts

**Statute:** Delaware's hospital lien law specifically provides that a hospital seeking to assert a lien must make the hospital records available for examination to the person who is legally liable or against whom a claim shall be asserted for compensation for injuries.<sup>3</sup>

## Special Access Laws

**Regulations:** Delaware has adopted as a regulation the standards of the Joint Commission on Accreditation of Hospitals. Standard III relating to the medical records department requires the written consent of the patient in order to release medical information to persons not generally authorized to receive it. In the absence of such consent, records may be removed from the hospital only by court order or subpoena. The requirements for confidential records vary in different programs of the Health Department.<sup>4</sup>

**Discovery:** Cases construing Delaware's discovery rules (generally the same as the Federal Rules of Civil Procedure) have held that where, in a personal injury action, injuries alleged are complex, and involve the testimony of several medical experts of different specialties, and where the taking of depositions as a prerequisite to the production of documents would involve unnecessary burdens to time and expense, a showing of good cause sufficient to allow hospital reports to be subject to discovery can generally be found. *Thompson v. E. R. Trucking Co.*, Del. Super. 1968, 249 A.2d 436 (1968), citing *Ariff v. Powers*, 479 Civil Action, Del. Super. 1966.

In cases involving medical malpractice which rise to the level of criminal negligence, including assault and battery and manslaughter, the State Department of Justice has broad powers of discovery and inspection through subpoena powers. Letter from Kent Walker, State Solicitor, to the Task Force; June 9, 1972.

capacity, whether the information was obtained from the patient, his family or persons in charge of him.<sup>1</sup> The privilege, however, does not apply to—

1. evidence in criminal cases where the accused is charged with causing the death of or injuring a person, and disclosure is necessary in the interests of public justice
2. evidence relating to the mental competency of an accused in criminal trials where the accused or the court raises the defense of insanity or in the pretrial or post-trial proceedings involving a criminal case where a question arises concerning the mental condition of the accused
3. evidence relating to the mental competency of a child in a proceeding before the Family Division of the Superior Court.

A separate statute extends the privilege to psychologists.<sup>2</sup>

**Case Law:** In a 1967 case the United States Court of Appeals for the District of Columbia held that the physician-patient privilege does not operate to relieve a hospital or doctor from the duty to reveal medical records to the next of kin of a deceased patient.<sup>3</sup> The statute applies to information in hospital records concerning diagnosis or treatment.<sup>4</sup>

## Medical Lien Acts

**Statute:** Pertains only to inspection of fiscal records.<sup>5</sup>

## Required Reports

**Statute:** Required reports of cases of cancer and malignant growths are made confidential and are not open to public inspection.<sup>6</sup> Only upon court order may the identity of the patient be divulged only on the written authorization of the director of public health.

## Special Access Laws

**Regulations:** In D.C. anyone may obtain access to hospital and medical records who has a legitimate interest in them, upon application accompanied by a written authorization for release by the patient or former patient, if an adult; or if a minor, by the parent or guardian. Hospital and clinical medical records are the property of the institution. Except in rare circumstances, a patient has access to his medical records, and if access were refused to the patient, it would be granted to his attorney.<sup>7</sup>

**Mental patients:** Records of mental patients are to be made available, upon the person's written authorization, to his attorney or personal physician. The records are to be preserved by the administrator until the patient has been discharged from the hospital. D.C. CODE § 21-562 (1967). A 1969 case held that the fact that the hospital to which a mentally ill person has been civilly committed may not, under this statute, disclose hospital records to outside parties without

<sup>1</sup> DEL. CODE ANN. tit. 24, § 3534 (Supp. 1970).

<sup>2</sup> See, e.g., DEL. CODE ANN. tit. 24, § 1741 (Supp. 1970).

<sup>3</sup> DEL. CODE ANN. tit. 25, § 4306 (1953).

<sup>4</sup> Letter from Harry F. Camper, Director, Bureau of Comprehensive Health Planning and Research, Division of Public Health to the Task Force, June 14, 1972.

## DISTRICT OF COLUMBIA

### Physician-Patient Privilege

**Statute:** D.C. has a privileged communications statute which applies to physicians and surgeons and prohibits disclosure without the consent of the patient or his legal representative of confidential information acquired in attending the patient and which was necessary to enable him to act in that



the patient's consent does not imply that it is forbidden to introduce them in court where they are relevant to the patient's contentions on habeas corpus. *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969).

In a 1971 case, the court said in a footnote, relying on § 21-562, that when a patient is committed to a public mental hospital for treatment, the hospital has a statutory obligation to make its records available to his counsel and to his personal physician, and justice demands no less for a patient who is committed to the hospital for observation in preparation for criminal trial. *United States v. Schappel*, 445 F.2d 716 (D.C. Cir. 1971). See also *Thornton v. Corcoran*, 407 F.2d 695, 702 f. (D.C. Cir. 1969) and *Washington v. United States*, 390 F.2d 444, 447 (D.C. Cir. 1967).

<sup>1</sup>D.C. CODE ANN. § 14-307 (Supp. V 1972).  
<sup>2</sup>D.C. CODE ANN. § 2-496 (Supp. V 1972).  
<sup>3</sup>*Emmett v. Eastern Dispensary and Casualty Hospital*, 396 F.2d 931 (D.C. Cir 1967).  
<sup>4</sup>*Ferguson v. Quaker City Life*, 129 A.2d 189 (D.C. Mun. App. 1957), see also, *Sher v. De Haven*, 199 F.2d 777 (D.C. Cir, 1952) cert. denied, 345 U.S. 936 (1953).  
<sup>5</sup>D.C. CODE ANN. § 38-304 (1967).  
<sup>6</sup>D.C. CODE § 6-1302 (1967).  
<sup>7</sup>Letter from Edward Harrigan, Legal Assistant, Department of Human Resources to the Task Force, June 12, 1972.

FLORIDA

Physician-Patient Privilege

Statute: There is no general physician-patient privilege in Florida. There is, however, a statutory psychiatrist-patient privilege which applies in civil and criminal cases.<sup>1</sup> However, the privilege does not apply if the patient introduces his mental condition as an element of his claim or defense. There are also certain limited statutory provisions for waiver of the privilege during court-ordered psychiatric examinations. The same privilege is applied by a separate statute to communications between psychologist and client.<sup>2</sup>

Public Record Acts

Statute: Florida's act making public records open to examination by citizens does not specifically exempt medical and hospital records.<sup>3</sup> It would appear that attorney general opinions have established some specific exemptions in this area.<sup>4</sup>

Regulations: With reference to state institutions, state hospitals, etc., unless the specific statute governing the institution or hospital provides for confidentiality of records, this would fall under Chapter 119 (see II-A, *supra*). Nevertheless, even in these instances, the medical personnel and administrators of the institutions follow the 'common law' practice of maintaining confidentiality

and considering such records to be the property of the hospitals.<sup>5</sup>

Special Access Laws

Statute: It is expressly provided by statute that a doctor making a physical or mental examination or treating a person, must, upon the request of the patient, his guardian, curator, or personal representative, furnish copies of all reports made of such examination or treatment.<sup>6</sup> Reports are not to be furnished to anyone else without the patient's consent, with the exception of a person or corporation who, with the patient's consent, procured or furnished the examination or where a compulsory physical examination is made pursuant to the Florida Rules of Civil Procedure.

Regulations: In Florida, medical records are considered confidential information between doctor and patient, and access to hospital and medical records is allowed only with the express permission of the patient himself or of the doctor in charge of the patient.<sup>7</sup> A patient's records may be released upon his signature on a waiver and release form, and submission by the party to whom the records are to be released of such form.<sup>8</sup> Records are considered to be the private property of the hospital.

Research: Statutes permit the release of medical information to certain study groups and state that the identity of the person studied shall remain confidential. FLA. STAT. ANN. §§ 405.01 et seq. (Supp. 1972). Mr. Eisenberg in letter cited above concludes: "... there exist elements of conflict in the practice and application of laws relating to medical records in the State of Florida."

<sup>1</sup>FLA. STAT. ANN. § 90.542 (Supp. 1972).  
<sup>2</sup>FLA. STAT. ANN. § 490.32 (Supp. 1972).  
<sup>3</sup>FLA. STAT. ANN. § 119.01 (1960).  
<sup>4</sup>1941 FLA. OP. ATT'Y GEN. 126; 1958 FLA. OP. ATT'Y GEN. 058-127. Cited from the statutory material in FLA. STAT. ANN. § 119.01 (1960)  
<sup>5</sup>Letter from Robert M. Eisenberg, General Council, Department of Health and Rehabilitative Services, to the Task Force, June 20, 1972.  
<sup>6</sup>FLA. STAT. ANN. § 458.16 (Supp. 1972).  
<sup>7</sup>Letter from George Palmer, M.D. To Task Force, June 12, 1972.  
<sup>8</sup>Letter from Robert M. Eisenberg; see note 5, *supra*.

GEORGIA

Physician-Patient Privilege

Statute: Georgia's confidential communications statute covers only psychiatrists.<sup>1</sup> A separate statute makes communications between psychologists and clients privileged.<sup>2</sup>  
Case Law: There is no confidential relationship between doctor and patient in Georgia.<sup>3</sup>

Psychiatrist-patient privilege is waived by calling doctor as witness to testify as to one's mental condition.<sup>4</sup>

### Public Record Acts

Statute: Medical records are exempt from public inspection. The identity of persons furnishing medical information incorporated in public health reports of the Department of Public Health are specifically protected from disclosure.<sup>5</sup>

The clinical record of a patient in a state hospital declared by statute not to be a public record.<sup>6</sup>

### Required Reports

Statute: Physicians and hospitals are required to report cases of venereal disease<sup>8</sup> and suspected cases of child abuse.<sup>9</sup>

### Special Access Laws

Statute: The clinical records of patients in state hospitals may not be released except to physicians, attorneys and government agencies as designated by the patient, or in response to a subpoena (except matters privileged under § 38-418 (5)).<sup>10</sup>

Regulations: Code § 38-418(5) (privilege for psychiatrists) has resulted in a practice of not releasing any medical records without the patient's authorization.

<sup>1</sup>GA. CODE ANN. § 38-418(5) (Supp. 1971).

<sup>2</sup>GA. CODE ANN. § 84-3118 (1970).

<sup>3</sup>Collins v. Howard, 156 F. Supp. 322, 324 (S.D. Ga. 1957).

<sup>4</sup>Fields v. State, 221 Ga. 307, 144 S.E.2d 339, 342 (1965).

<sup>5</sup>GA. CODE ANN. § 40-2703 (1971).

<sup>6</sup>GA. CODE ANN. § 88-502.10 (a) (Supp. 1971).

<sup>7</sup>GA. CODE ANN. § 67-2207 to 67-2213 (1967).

<sup>8</sup>GA. CODE ANN. § 88-1602 (1971).

<sup>9</sup>GA. CODE ANN. § 74-111 (Supp. 1971).

<sup>10</sup>GA. CODE ANN. § 88-502.10 (1971).

## HAWAII

### Physician-Patient Privilege

Statute: A Physician may not divulge information acquired in attending a patient in any civil action, unless the sanity of the patient is the matter in dispute. The privilege is waived in personal injury suits or where the party offers himself or physician as a witness to testify as to his physical condition.<sup>1</sup>

### Required Reports

Statute: Cases of injuries suspected to be caused by violence are required to be reported,<sup>2</sup> as well as cases of child abuse<sup>3</sup> and communicable diseases.<sup>4</sup> Identity of latter patients are not to be made public.<sup>5</sup>

### Special Access Laws

Statute: Information from court-ordered physical examination in personal injury action may be divulged without the consent of the person examined.<sup>6</sup>

Records of patients in mental facilities are not to be disclosed except as the patient consents or as the court may order.<sup>7</sup>

<sup>1</sup>HAWAII REV. STAT. § 621-20 (1968).

<sup>2</sup>HAWAII REV. STAT. § 453-14 (1968).

<sup>3</sup>HAWAII REV. STAT. § 350 (1968).

<sup>4</sup>HAWAII REV. STAT. § 325-4 (1968).

<sup>5</sup>HAWAII REV. STAT. § 325-4 (1968).

<sup>6</sup>HAWAII REV. STAT. § 625-12 (1968).

<sup>7</sup>HAWAII REV. STAT. § 334-5 (1968).

## IDAHO

### Physician-Patient Privilege

Statute: A physician cannot, without the consent of his patient, be examined in a civil action as to any information acquired in attending patient except (1) in cases of child abuse, (2) after patient's death in any action involving the validity of his will, (3) in personal injury actions, and, (4) in an action by a beneficiary to recover on life insurance policy.<sup>1</sup>

In a criminal trial where the defendant raises defense of mental illness, statements made to an examining psychiatrist are admissible upon the issue of his mental condition whether or not it would otherwise be deemed a privileged communication.<sup>2</sup>

License to practice medicine is subject to revocation for willful betrayal of professional secret or willful violation of privileged communication except as required by law.<sup>3</sup>

Case Law: Privilege does not apply to criminal cases.<sup>4</sup>

Privilege may be waived by personal representative or heirs of decedent.<sup>5</sup>

### Required Reports

Statute: Physicians and hospitals are required to report cases of child abuse.<sup>6</sup>

### Special Access Laws

Statute: Records of patients hospitalized for mental illness are not to be disclosed except (1) by the patient's consent or (2) as a court may direct.<sup>7</sup>

<sup>1</sup>IDAHO CODE § 9-203 (4) (Supp. 1971).

<sup>2</sup>IDAHO CODE § 18-409 (Supp. 1971).

<sup>3</sup>IDAHO CODE § 54-1810 (h)(2) (Supp. 1971).

<sup>4</sup>State v. Coburn, 82 Idaho, 437, 354 P.2d 751, 756-7 (1960).

<sup>5</sup>In re Groan's Estate, 83 Idaho 568, 366 P.2d 831, 836 (1961).

<sup>6</sup>IDAHO CODE § 16-1641 (Supp. 1971).

<sup>7</sup>IDAHO CODE § 66-348 (a) (Supp. 1971).

## ILLINOIS

## Physician-Patient Privilege

Statute: Illinois recognizes the physician-patient privilege,<sup>1</sup> which prohibits any physician from disclosing any information acquired in attending a patient in a professional relationship which is necessary for treatment. However, the privilege does not apply: (1) in homicide cases where the disclosure relates directly to the fact or immediate circumstances of the homicide; (2) in malpractice actions against a physician; (3) with the consent of the patient or, if deceased or disabled, his personal representative or the beneficiary of an insurance policy; (4) in all civil suits brought by or against a patient or his personal representative where the patient's physical or mental condition is an issue; (5) in a will contest; (6) in any criminal action where abortion, murder by abortion, or attempted abortion is a charge; (7) in actions arising from a required child abuse report.

A psychiatrist-patient privilege is also recognized in Illinois.<sup>2</sup> It provides that a patient or his authorized representative and a psychiatrist or his authorized representative have the privilege to refuse to disclose and to prevent a witness from disclosing communications relating to diagnosis or treatment of the patient's mental condition between the patient and psychiatrist or members of the patient's family and the psychiatrist. The privilege does not apply, however: (1) in hospitalization proceedings initiated by the psychiatrist; (2) if the patient, having been warned that communications would not be privileged, makes communications to a psychiatrist during a court ordered psychiatric examination; (3) in a civil or administrative proceeding in which the patient or his personal representative introduced his mental condition as an element of his claim or defense, except that the privilege may be asserted in any divorce action unless the patient or the psychiatrist on behalf of the patient testifies first to privileged communications, or (4) in any proceeding brought by the patient against his psychiatrist and in any criminal or license revocation proceeding where the patient is a complaining witness and disclosure is relevant to the claim or defense of the psychiatrist.

If the provisions of the physician-patient privilege come in conflict with those of the psychiatrist-patient privilege, the latter govern.

## Hospital Lien Acts

Statutes: Illinois' hospital lien law<sup>3</sup> applies to nonprofit and county-operated hospitals. When a lien is asserted by a hospital any defendant to the action may, upon written request, inspect the records of the injured party. A defendant may also request a written statement of the nature and extent of the injuries sustained by the plaintiff, the

treatment given him and how the injuries were received, if given by the injured person and contained in the records. A comparable physician's lien has also been established.<sup>4</sup>

## Required Reports

Statutes: Reports are required of physicians who treat children who have been subjected to physical abuse.<sup>5</sup>

## Special Access Laws

Statutes: A recent Illinois law allows inspection and copying of a patient's hospital records by his physician or authorized attorney upon demand of the patient.<sup>6</sup> The act is made inapplicable to certain mental hospitals.<sup>7</sup>

<sup>1</sup> ILL. ANN. STAT. ch. 51 § 5.1 (Smith-Hurd 1966).

<sup>2</sup> ILL. ANN. STAT. ch. 51, § 5.2 (Smith-Hurd Supp. 1972).

<sup>3</sup> ILL. ANN. STAT. ch. 82, §§ 97-101 (Smith-Hurd 1966).

<sup>4</sup> ILL. ANN. STAT. ch. 82, §§ 101.3-5 (Smith-Hurd 1966).

<sup>5</sup> ILL. ANN. STAT. ch. 23, §§ 2041 et seq. (Smith-Hurd Supp. 1972).

<sup>6</sup> ILL. ANN. STAT. ch. 51, § 71 (Smith-Hurd Supp. 1972).

<sup>7</sup> ILL. ANN. STAT. ch. 51, § 72 (Smith-Hurd Supp. 1972).

## INDIANA

## Physician-Patient Privilege

Statute: Physicians are incompetent witnesses as to matters communicated to them by patients in the course of their professional business and as to advice given in such papers.<sup>1</sup> It is not clear whether the privilege applies to medical records.

Case Law: The privilege is waived when a patient sues a physician for malpractice.<sup>2</sup> Also, if a patient puts his physical condition in issue in a personal injury suit, he waives the privilege.<sup>3</sup>

Regulations: An Attorney General's opinion provides that an indigent in a state hospital does not lose the privilege of confidentiality as to information in his hospital records.<sup>4</sup>

## Public Records Acts

Statutes: The anti-secrecy law<sup>5</sup> excludes confidential records and thus medical records are not open to the public.

## Medical Lien Acts

Statutes: The Indiana hospital lien law<sup>6</sup> does not provide for inspection of hospital records by parties to the action.

## Required Reports

Statutes: Reports are required of physicians who treat patients with tuberculosis.<sup>7</sup> Any person who

has reason to believe a child has been physically abused is required to report that information to a law enforcement agency or the county department of public welfare.<sup>6</sup> The physician-patient privilege does not exclude evidence in a proceeding arising from a child abuse report.<sup>9</sup>

- <sup>1</sup>IND. ANN. STAT. § 2-1714(4) (1968).  
<sup>2</sup>Lane v. Boicourt, 128 Ind. 420, 27 N.E. 1111 (1891).  
<sup>3</sup>Northern Indiana Public Service Co. v. McClure, 108 Ind. App. 24 N.E.2d 788 (1940).  
<sup>4</sup>1945 IND. OP. ATTY GEN. 200.  
<sup>5</sup>IND. ANN. STAT. § 57-606 (1961).  
<sup>6</sup>IND. ANN. STAT. §§ 43-501 to 502 (1965).  
<sup>7</sup>IND. ANN. STAT. §§ 35-1211 to 1212 (1969).  
<sup>8</sup>IND. ANN. STAT. §§ 52-1426 to 1431 (Supp. 1971).  
<sup>9</sup>IND. ANN. STAT. § 52-1430 (Supp. 1971).

## IOWA

### Physician-Patient Privilege

Statutes: A physician is not allowed to reveal confidential communications entrusted to him in his professional capacity and necessary to enable him to discharge the functions of his office. However, the privilege is waived by the filing of a personal injury action.<sup>1</sup>

Case Law: The privilege has been held waived where a doctor was called as a witness and examined directly.<sup>2</sup>

### Public Record Acts

Statutes: The Public Records Law recently added<sup>3</sup> allows the public access to records, but specifically excepts hospital records, making them confidential unless otherwise ordered by a court, the lawful custodian of the records or another person duly authorized to release information.<sup>4</sup>

### Medical Lien Acts

Statutes: The hospital lien law<sup>5</sup> does not provide for inspection of hospital records.

### Required Reports

Statutes: The Venereal Disease Control Act<sup>6</sup> requires physicians to make reports to the state health department upon examination or treatment of a diseased person. The reports are to be kept confidential to the extent necessary to prevent identification of persons named therein.

### Special Access Laws

Statutes: No statute exists in Iowa specifically providing for access to hospital records.

Under Iowa common law, medical and hospital records are privileged and would not be available except to the patient.<sup>7</sup>

- <sup>1</sup>IOWA CODE ANN. § 622.10 (Supp. 1972).  
<sup>2</sup>State v. Mayhew, 170 N.W.2d 608 (Iowa 1969).  
<sup>3</sup>IOWA CODE ANN. §§ 68A.1-9 (Supp. 1972).  
<sup>4</sup>IOWA CODE ANN. § 68A.7 (Supp. 1972).

<sup>5</sup>ATWA CODE ANN. §§ 582.1-4 (1946).

<sup>6</sup>IOWA CODE ANN. §§ 140.1-4 (1972).

<sup>7</sup>Letter from Peter J. Fox, Hearing Officer, Iowa Department of Health, to the Task Force, June 12, 1972.

## KANSAS

### Physician-Patient Privilege

Statute: Communications between physician and patient are privileged in civil actions and prosecutions for a misdemeanor except:

- 1) in an action to commit the patient for mental illness,
- 2) upon the issue of validity of will,
- 3) upon an issue between parties claiming by intestate succession, and
- 4) where the condition of the patient is an element of a claim or defence.<sup>1</sup>

Unprofessional conduct includes willful betrayal of confidential information.<sup>2</sup>

Psychologist-client communications enjoy the same privilege as attorney-client.<sup>3</sup>

Case Law: Privilege can be waived by patient<sup>4</sup> or his heirs<sup>5</sup>.

### Required Reports

Statutes: Physicians must report suspected cases of child abuse,<sup>6</sup> to which privilege is not applicable.<sup>7</sup>

### Special Access Laws

Statutes: Records of the mentally ill are not to be disclosed except on consent of the patient, on court order, or the proceedings under the act upon request of the patient's attorney.<sup>8</sup>

Regulations: Medical records are the property of the hospital. Only authorized personnel shall have access.<sup>9</sup>

<sup>1</sup>KAN. STAT. ANN. § 60-427 (1965).

<sup>2</sup>KAN. STAT. ANN. § 65-2837 (f) (1964).

<sup>3</sup>KAN. STAT. ANN. § 74-5323 (1964).

<sup>4</sup>Sodom v. Gemberling, 188 Kan. 716, 366 P.2d 235, 238 (1961).

<sup>5</sup>Fish v. Poorman, 85 Kan. 237, 116 P. 898 (1911).

<sup>6</sup>KAN. STAT. ANN. § 38-717 (Supp. 1970).

<sup>7</sup>KAN. STAT. ANN. § 38-719 (Supp. 1970).

<sup>8</sup>KAN. STAT. ANN. § 59-2931 (Supp. 1970).

<sup>9</sup>Kansas Board of Health, Hospital Regulations § 28-34-10.

## KENTUCKY

### Physician-Patient Privilege

Statute: The physician-patient privilege in Kentucky is very narrow, applicable only to transactions coming within the purview of the bureau of vital statistics.<sup>1</sup> However, a separate statute provides that confidential communications between psychologist and client are placed on the same privileged basis as those between attorney and



client, for the purposes of the chapter dealing with licensing of psychologists and the practice of psychology in the state.<sup>2</sup>

There is also a statutory psychiatrist-patient privilege, enacted in 1966, which applies to all proceedings.<sup>3</sup> It encompasses communications relating to diagnosis or treatment of the patient's mental condition between patient and psychiatrist, or between members of the patient's family and the psychiatrist, or between any of the foregoing and persons who participate in the diagnosis and treatment under the supervision of the psychiatrist. Exceptions to the privilege include:

1. when the psychiatrist determines that the patient is in need of commitment or admission to a hospital for treatment of mental illness

2. if a judge finds the patient has waived the privilege during a court-ordered psychiatric examination

3. in a civil proceeding in which the patient introduces his mental condition as an element of his claim or defense, and the judge finds that disclosure is in the interests of justice.

Case Law: Two cases make it very clear that the physician-patient privilege applies only to reports required to be filed with the bureau of vital statistics and does not render privileged communications between physician and patient generally.<sup>4</sup>

#### Special Access Laws

Regulations: A State Board of Health regulation provides that records are the property of the institution and can only be taken from the institution by court order. However, the record or a part thereof may be routed to a physician for consultation. Records are available, when requested, for inspection by duly authorized representatives of the State Board of Health.<sup>5</sup>

**Mental patients:** Records of mental patients are made confidential by statute and cannot be disclosed without the consent of the patient. However, the following exceptions are provided:

1. consent of individual
2. disclosure necessary to carry out provisions of Kentucky law
3. disclosure necessary to comply with official inquiries of federal agencies
4. court determines disclosure necessary to the proceedings before it, and failure to disclose would be contrary to the public interest.

In addition, disclosure of information as to the medical condition of the patient is allowed, upon proper inquiry to family or friends. KY. REV. STAT. § 210.235 (1972).

**Medical Lab Tests:** Records of laboratory may be made available to representatives of the Kentucky State Department of Health for inspection during regular office hours. KY. REV. STAT.

ANN. § 333.180 (1969). See also §§ 333.130, 333.140 (1969).

**Discovery:** See also *Matthew v. Farabee*, 407 S.W.2d 131 (Ky. 1966); *Christoff v. Downing*, 309 S.W.2d 153 (Ky. 1965); *Bender v. Eaton*, 343 S.W.2d 799 (Ky. 1971).

<sup>1</sup>KY. REV. STAT. § 213.200 (1972).

<sup>2</sup>KY. REV. STAT. ANN. § 319.111 (1969).

<sup>3</sup>KY. REV. STAT. ANN. § 421.215 (Cum. Supp. 1968).

<sup>4</sup>*Boyd v. Wynn*, 286 Ky. 173, 150 S.W.2d 648 (1941); *Williams v. Tarter*, 286 Ky. 717, 151 S.W.2d 783 (1941).

<sup>5</sup>Kentucky Board of Health Reg. HL-1.

## LOUISIANA

### Physician-Patient Privilege

Statute: There is a statutory physician-patient privilege in Louisiana which has been construed to apply only in criminal proceedings.<sup>1</sup> It encompasses communications made to the physician as a physician by or on behalf of his patient, or the result of examination into the patient's physical or mental condition, medical opinion, or other information. The privilege does not apply to any physician appointed by the court to investigate the patient's physical or mental condition. In addition, any physician may be cross-examined upon the correctness of any certificate issued by him. Whatever privilege a patient may have regarding communications with his doctor or hospital, once the patient institutes a suit in the prosecution or defense of which such communications or records are necessary and relevant, no privilege exists (*Pennison v. Provident Life & Accident Ins. Co.*, see note 6, *infra*).

Case Law: The physician-patient privilege applies only to criminal proceedings. There is no physician-patient privilege in civil actions in Louisiana.<sup>2</sup>

### Public Record Acts

Statute: Hospital records are exempt from the disclosure provisions for public records *except* when the condition of a patient admitted to a general hospital is due to an accident, poisoning, negligence or presumable negligence resulting in any injury, assault or any act of violence or a violation of the law.<sup>3</sup> Governing authorities of hospitals may make rules under which these reports may be exhibited and copied by those legitimately interested. According to an Attorney General Opinion of 1971, when a hospital determines that the condition of the patient is such that his hospital records are not exempted from disclosure (i.e., condition due to accident, poisoning, negligence, etc.), the records are still only available to those persons legitimately and properly interested in the disease or the condition of the patients, and the board of the hospital is authorized to make and



enforce reasonable rules to determine who is legitimately interested.<sup>4</sup>

### Special Access Laws

**Statute:** Superintendents of all general hospitals administered by the state must furnish upon written request of the referring doctor, a report to the doctor on the patient upon the patient's discharge.<sup>5</sup> Such report must show diagnosis, laboratory and x-ray findings, and treatment prescribed. Superintendents must further furnish, on written request, a full report on the patient to the patient, his attorney, or the patient's heirs or their attorney.

**Case Law:** A physician has been held not liable where he has made a disclosure of confidential information about his patient to her spouse. During marriage, even when the parties are living apart, the husband as head of the marital community, has the right to obtain a full medical report from his wife's doctor.<sup>6</sup>

**Regulations:** Under Louisiana law, hospital records of a medical nature are available to:<sup>7</sup>

1. patient's physician
2. consulting physician
3. residents and interns on a need-to-know basis in a training hospital
4. paramedical personnel on a need-to-know basis
5. the patient; after discharge, the former patient has a clear right to examine and copy his medical records. Some private hospitals have established regulations which require the consent of the patient's physician in advance of such access. However, it is the opinion of the General Counsel of the State Department of Hospitals that such regulations are contrary to Louisiana law. An unsettled question is the right of the patient to access to his hospital record during his stay in the hospital. It is the personal view of the General Counsel that a hospital may establish reasonable regulations governing the patient's access to his own record while he is hospitalized.
6. duly authorized representatives of the patient (e.g., attorney). The same rules that apply to the patient after discharge from the hospital apply to his representative. Again, some private hospitals have attempted to establish regulations governing access; however, the opinion of the General Counsel is that these regulations are contrary to state law.
7. in answer to a subpoena from a court of competent jurisdiction.
8. law enforcement officials in certain instances, patients who are involved in accidental trauma (e.g., car wrecks) and cases of real or suspected crimes of violence, whether the patient is the victim or the aggressor.

9. various hospital committees as provided under Medicare.<sup>8</sup>

In general, except as provided under Medicare, recognized educational endeavors (for statistical purposes only), and by subpoena, no one has a right to an ex-patient's hospital record without his signed consent. The ex-patient is protected under a right to privacy and in state hospitals by the exemption to the public records act discussed in II-A, *supra*. In the event of a deceased patient, access to records would be granted to his legal representative as determined in succession proceedings.

Upon transfer of a patient from one mental institution to another, all of the patient's records or a full abstract must be sent.<sup>9</sup>

Superintendents of state hospitals for the mentally ill must, upon written request of the coroner of the parish from which the patient was committed, furnish a report on the patient's condition. Upon written request of the patient's attorney or a near relative, the medical record must be made available for inspection.<sup>10</sup>

<sup>1</sup>LA. REV. STAT. ANN. § 15: 476 (1967).

<sup>2</sup>*Moosa v. Abdalla*, 248 La. 344, 178 So.2d 273 (1965).

<sup>3</sup>LA. REV. STAT. ANN. § 44: 7, (Supp. 1972), and LA. REV. STAT. ANN. § 44: 31 (1951).

<sup>4</sup>LA. OP. ATTY GEN. March 23, 1971 and 1950-52 LA. OP. ATTY GEN. 202. The latter is cited from the statutory annotation to § 44: 7 (Supp. 1972).

<sup>5</sup>LA. REV. STAT. ANN. § 40: 2014.1 (1965).

<sup>6</sup>*Pennison v. Provident Life & Accident Ins. Co.*, 154 So.2d 617 (La. App. 1963), cert. denied, 244 La. 1019, 156 So.2d 226 (1963). See also *Mangrum v. Powell*, 181 So.2d 400 (La. Ct. App. 1965).

<sup>7</sup>Letter from Thomas W. Landry, General Counsel, State Department of Hospitals, to the Task Force, June 12, 1972.

<sup>8</sup>See LA. REV. STAT. ANN. § 40: 2017.9 (Supp. 1972).

<sup>9</sup>LA. REV. STAT. ANN. § 28: 94 (1969).

<sup>10</sup>LA. REV. STAT. ANN. § 40: 2013.3 (1965).

## MAINE

### Physician-Patient Privilege

**Statute:** Maine's privileged communications statute, which was enacted in 1969, provides that no licensed physician, in any civil or criminal action, without the patient's consent, may disclose information acquired in attending the patient in a professional capacity, if such information was necessary to enable him to furnish professional care to the patient.<sup>1</sup> The privilege, however, does not apply in the following cases:

1. when the physical or mental condition of the patient is at issue in the action.
2. when a court in its discretion deems disclosure necessary in the interests of justice.
3. when disclosure of information is required by law.

### Medical Lien Acts

**Statute:** Under the hospital lien law, hospitals must make their records available in order to determine the reasonableness of charges.<sup>2</sup> The statute, however, forbids disclosure of records with regard to the nature of the patient's injury, condition or state of recovery.

### Special Access Laws

**Statute:** Records of mental patients are made confidential.<sup>3</sup> The following exceptions exist:

1. consent of individual
2. necessity
3. court directive.

The statute also provides that information as to a mental patient's current condition may be disclosed upon inquiry to his relatives or friends. Other specified limited disclosures are allowed, e.g., to other hospitals or accredited social agencies for purposes of research. In 1966 a section was added to allow disclosure of biographical or medical information to commercial or government insurers or any other association from which the department may be reimbursed for treatment of the patient. In 1969 provisions were added to allow disclosure of information in connection with educational or training programs provided the identity of the patient remains confidential. Willful violations of the statute are punishable as misdemeanors.

**Regulations:** The following proposed regulations are scheduled to be adopted this summer. The regulations are substantially taken from federal regulations relating to conditions of participation for hospitals in the Federal Health Insurance for the Aged program:<sup>4</sup>

- medical records are confidential
- only authorized personnel have access to the records
- written consent of the patient is presented as authority for release of medical information
- medical records are not generally removed from the hospital environment except upon subpoena.

An Attorney General opinion of 1951 stated that an attorney should be granted permission to inspect any record which is open to the inspection of his client. The attorney has no stronger right than the client-patient to see the record.<sup>5</sup>

<sup>1</sup>ME. REV. STAT. ANN. tit. 32, § 3153 (Supp. 1972).

<sup>2</sup>ME. REV. STAT. ANN. tit. 10, § 3412 (Supp. 1972).

<sup>3</sup>ME. REV. STAT. ANN. tit. 34, § 2256 (Supp. 1972).

<sup>4</sup>Letter from Robert B. Calkins, Assistant Attorney General, to the Task Force, June 19, 1972.

<sup>5</sup>1951-54 ME. ATTY GEN. REP. 70.

## MARYLAND

### Physician-Patient Privilege

**Statute:** Maryland has a statutory privilege for communications between patient and psychiatrist, between patient and certified psychologist, between a patient and other patients receiving group treatment, or between members of patient's family and the psychiatrist or psychologist.<sup>1</sup> The privilege is applicable in civil or criminal cases. However, an exception is made for cases involving the custody of children, where the court may in its discretion, compel disclosure. In addition, there is no privilege in the following situations:

1. When necessary for the purpose of placing the patient in a mental health facility.
2. if the judge finds a waiver during a court-ordered examination.
3. in any proceeding in which the patient introduces his mental condition as an element of his claim or defense
4. in malpractice actions against the psychiatrist or psychologist
5. in Art. 31B proceedings relating to defective delinquency proceedings
6. where the patient or his personal representative consents

### Public Record Acts

**Statute:** In an exception to the disclosure provisions of the Public Record Act, citizens are denied the right to inspect medical, psychological and sociological data on individual persons, exclusive of coroners' autopsy reports, hospital records relating to medical administration, medical staff personnel, medical care, and other medical information, whether on individual persons or groups, or whether of a general or specific classification.<sup>2</sup>

### Medical Lien Acts

**Statute:** Maryland's hospital lien law allows inspection of hospital records to ascertain charges and estimate the lien, provided notice of the inspection is mailed to the patient.<sup>3</sup>

<sup>1</sup>MD. ANN. CODE art. 35 § 13A (1971).

<sup>2</sup>MD. ANN. CODE art. 76A § 3 (Supp. 1971).

<sup>3</sup>MD. ANN. CODE art 63 §49 (1972).

## MASSACHUSETTS

### Physician-Patient Privilege

**Statutes:** Massachusetts does not recognize the physician-patient privilege.

## Medical Lien Acts

**Statutes:** The Massachusetts hospital lien law does not contain a provision for the inspection of hospital records.<sup>1</sup>

## Required Reports

**Statutes:** Massachusetts law requires that any person with a venereal disease be reported to the local board of health, but makes no provision for confidentiality, leaving rules and regulations governing the area up to the state health department.<sup>2</sup>

A physician who has reason to believe that a child has been physically abused is required to report the injury to the department of public welfare.<sup>3</sup>

## Special Access Laws

**Statutes:** A statute<sup>4</sup> provides for the keeping of hospital records and has, since 1945, permitted the patient or his authorized attorney to inspect the records and obtain a copy for a reasonable fee. Inspection is also permitted by judicial order but inspection of records of mental hospitals is not allowed. This early approach to the problem of access to hospital records has resulted in little difficulty in obtaining records, as reflected by the absence of cases involving the statute.

**Case Law:** The Supreme Judicial Court has held that the refusal to permit a patient at a mental hospital to examine and obtain copies of records of his involuntary admission and detention did not violate a constitutional provision making officers of the government accountable to the people.<sup>5</sup>

**Regulations:** The statute makes no provision for inspection of records of deceased patients. An attorney general opinion held that if a deceased patient has not executed a written authorization for an inspection of records, such an inspection may be accomplished only by judicial order.<sup>6</sup>

<sup>1</sup>MASS. GEN. LAWS ANN. ch. 111 § 70A-D (1971).

<sup>2</sup>MASS. GEN. LAWS ANN. ch. 111 § 111 (1971).

<sup>3</sup>MASS. GEN. LAWS ANN. ch. 119 § 39A-B (1969).

<sup>4</sup>MASS. GEN. LAWS ANN. ch. 111 § 70 (1971).

<sup>5</sup>*Bane v. Superintendent of Boston State Hospital*, 350 Mass. 637, 216 N.E. 2d 111 (1966), cert. denied 385 U.S. 842.

<sup>6</sup>1963-64 MASS. OP. ATT'Y GEN. 231 (1964).

## MICHIGAN

### Physician-Patient Privilege

**Statutes:** Michigan recognizes the physician-patient privilege,<sup>1</sup> but the privilege is waived if a patient brings a personal injury or malpractice suit and produces a physician who has treated him as a witness in his behalf. Since expert testimony is required in most personal injury and malpractice

suits in order to prove damages, the privilege would of necessity be waived in most suits of this nature. Medical records are considered confidential, also.<sup>2</sup>

**Case Law:** A recent case held that when defendant moves to depose plaintiff's physicians, plaintiff-patient must decide whether to assert the privilege or to allow deposition to continue. If the patient asserts the privilege at the deposition stage, the opposing party is precluded from obtaining privileged information, but the patient is precluded from using the privileged matters at a subsequent trial.<sup>3</sup> However, if the patient permits the deposition to continue, he does not waive his right to invoke the privilege at a later time.<sup>4</sup>

## Required Reports

**Statutes:** Doctors are required to make reports of venereal disease,<sup>5</sup> tuberculosis,<sup>6</sup> and child abuse.<sup>7</sup> The physician-patient privilege does not bar testimony in cases involving child abuse.

## Special Access Laws

**Statutes:** A recent act requires a complete record to be kept for every patient and provides that a state health official may not divulge the contents of a patient's record so as to identify an individual except on court order.<sup>8</sup> As this law is not specific and seems to apply only to state health officials it is of little value in obtaining access to hospital records.

<sup>1</sup>MICH. COMP. LAWS ANN. § 600.2157 (1967).

<sup>2</sup>Letter from John L. Isbister, M.D., Michigan Department of Public Health, to the Task Force, June 13, 1972.

<sup>3</sup>*Eberle v. Savon Food Stores, Inc.*, 30 Mich. App. 496, 186 N.W.2d 837 (1971).

<sup>4</sup>*Id.* at 839.

<sup>5</sup>MICH. COMP. LAWS ANN. § 329.152-202 (1967).

<sup>6</sup>MICH. COMP. LAWS ANN. § 329.401 (1967).

<sup>7</sup>MICH. COMP. LAWS ANN. § 722.571-574 (Supp. 1972).

<sup>8</sup>MICH. COMP. LAWS ANN. § 331.420 (Supp. 1972).

## MINNESOTA

### Physician-Patient Privilege

**Statutes:** A physician shall not disclose any confidential information acquired in his professional capacity without the consent of his patient.<sup>1</sup> The statute also provides for waiver by beneficiaries in an action to recover insurance benefits if the insurance has been in existence for two years or more.

The Minnesota Rules of Civil Procedure provide that a party waives any privilege he might have with regard to the testimony of a person who has



examined him if at any stage of an action the party voluntarily places in controversy the physical, mental, or blood condition of himself, a decedent or a person under his control.<sup>2</sup> This rule brings Minnesota in line with the majority of states recognizing the physician-patient privilege by deeming it waived by the introduction in issue of physical or mental condition.

Regulations: Privileged matter in the records of municipally owned hospitals is not public.<sup>3</sup>

### Medical Lien Acts

Statutes: The Minnesota hospital lien law does not provide for the inspection of hospital records.<sup>4</sup>

### Required Reports

Statutes: Physicians are required to report incidents of child abuse,<sup>5</sup> and tuberculosis.<sup>6</sup> Reports of child abuse may be received into evidence notwithstanding the physician-patient privilege.<sup>7</sup>

<sup>1</sup> MINN. STAT. ANN. § 595.02 (4) (Supp. 1972).

<sup>2</sup> MINN. R. CIV. P. Rule 35.03.

<sup>3</sup> 1954 MINN. OP. ATT'Y GEN. 851-K.

<sup>4</sup> MINN. STAT. ANN. § § 514.68-.72 (1947).

<sup>5</sup> MINN. STAT. ANN. § 626.554 (Supp. 1972).

<sup>6</sup> MINN. STAT. ANN. § 144.42 (1945).

<sup>7</sup> MINN. STAT. ANN. § 626.554(6) (Supp. 1972).

## MISSISSIPPI

### Physician-Patient Privilege

Statute: Mississippi has a privileged communications statute which applies to physicians and surgeons in any legal proceeding to bar disclosure without consent of the patient, or in case of the death of the patient, by his personal representative or legal heirs, or if the validity of the will of the decedent is in question, by the personal representative, legal heirs, or any contestant or proponent of the will.<sup>1</sup> The statute also implies a waiver of the medical privilege of cancer patients with regard to information necessary for the Tumor Registry Agency (to be used for statistical reports only and patient's name is not to be disclosed). There is a separate statutory right to waive the privilege given to any person who has the power to consent to surgical or medical procedures.<sup>2</sup> The waiver or consent survives the death of the person giving it. Waiver is not necessary for the furnishing of information to the Tumor Registry Agency.

### Record Acts

Statute: Hospital records are not considered public records in Mississippi, except as otherwise provided by law.<sup>3</sup>

### Required Reports

Statute: The boards of trustees of hospitals must make monthly reports to the State Hospital Commission of patients cared for, treated, and hospitalized and for which reimbursement of cost is sought.<sup>4</sup>

### Special Access Laws

Statute: A statute expressly states that records are hospital property, subject however to reasonable access to the information contained therein upon good cause shown by the patient, his personal representatives or heirs, his attending medical personnel and his duly authorized nominees, upon payment of any reasonable charges for such service.<sup>5</sup>

Regulations: Due care shall be taken to prevent records from being withdrawn, destroyed or examined by unauthorized persons. The licensing agency shall be given reasonable access to the medical records for inspection and examination.<sup>6</sup> *Mental patients:* Records pertaining to persons committed to Mississippi State Hospital or East Mississippi Hospital are confidential. They may be divulged only by signed waiver by the person committed or by an order of a court of competent jurisdiction. An exemption is made in the case of cancer patients for information needed by the Tumor Registry Agency, which is not to disclose the identity of the patient. MISS. CODE ANN. §436-09 (Supp. 1971) *Disclosure to state agencies:* From time to time, information may be released from hospital records to state agencies. Statutes make it a misdemeanor to improperly disclose records in such cases. See, e.g., MISS. CODE ANN. §6508.5-12 and §6504.8 (1952).

<sup>1</sup> MISS. CODE ANN. § 1697 (Supp. 1971).

<sup>2</sup> MISS. CODE ANN. § 7129-85 (Supp. 1971).

<sup>3</sup> MISS. CODE ANN. § 7146-59 (Supp. 1971).

<sup>4</sup> MISS. CODE ANN. § 7139 (Supp. 1971).

<sup>5</sup> MISS. CODE ANN. § 7146-53 (Supp. 1971).

<sup>6</sup> Minimum Standards of Operation for Hospitals Mississippi Commission on Hospital Care, § § 2401 c.d. (1966).

## MISSOURI

### Physician-Patient Privilege

Statute: Physicians or surgeons are incompetent witnesses as to any information acquired from any patient while attending him in a professional character and which information was necessary to treat him in a professional capacity.<sup>1</sup> *Waiver of privilege:* A 1968 case held that the physician-patient privilege is deemed to be waived once issue has been

joined in a personal injury action as to the extent of the plaintiff's injuries, so that the defendant may obtain medical and hospital records for discovery purposes over the plaintiff's objection of privilege under the statute. *State ex rel. McNutt v. Keet*, 432 S.W.2d 597, (1968).

**Case Law:** This statute applies to medical records.<sup>2</sup> A 1968 case held that a trial court's order allowing the plaintiff to examine numerous hospital records unmasked so he could designate those he desired produced and copied was improper as permitting the plaintiff to discover privileged matter without providing adequate safeguards.<sup>3</sup> A 1969 case held that this state statute could not be applied to prevent enforcement of an internal revenue summons seeking production of decedent's hospital records.<sup>4</sup>

### Special Access Laws

**Regulations:** Records or excerpts can be released from the record room only on written order of the patient and his attending physician or dentist or by the legal process. They may, however, be released on the order of the administrator for purposes of research and study by qualified persons.<sup>5</sup>

<sup>1</sup>MO. ANN. STAT. § 491.060 (1952).

<sup>2</sup>*State ex rel. Benoit v. Randall*, 431 S.W.2d 107 (Mo. 1968).

<sup>3</sup>*Id.*

<sup>4</sup>*United States v. Kansas City Lutheran Home & Hosp. Assn.*, 297 F. Supp. 239 (W.D. Mo. 1969).

<sup>5</sup>Missouri Division of Health, Hospital Licensing Law, ch. 197 R.S. Mo.

## MONTANA

### Physician-Patient Privilege

**Statute:** Physician cannot be examined in a civil action as to information acquired in attending patient without the consent of his patient.<sup>1</sup> Privilege is waived by commencing action which places in issue the physical or mental condition of the party.<sup>2</sup>

A psychologist employed by an educational institution cannot be examined as to communications made to him in confidence by a duly registered student of such institution unless by consent of the student, or, if a minor, by student and his parents.<sup>3</sup>

Psychologist-client communications are privileged on the same basis as attorney-client communications.<sup>4</sup>

**Case Law:** Privilege can be waived only by patient, not by doctor.<sup>5</sup>

Privilege statute does not apply to criminal actions.<sup>6</sup>

### Required Reports

**Statute:** Physicians must report suspected cases of child abuse,<sup>7</sup> reports of which are not to be excluded from evidence on the ground of privilege.<sup>8</sup>

Physicians must also report cases of venereal disease,<sup>9</sup> but information concerning persons infected can only be released to state department of health or a physician upon written consent of the person whose record is requested.<sup>10</sup>

### Special Access Laws

**Regulations:** Hospital records are to be kept confidential. They are the property of the hospital and may be removed from the hospital only with official permission. Only authorized personnel may have access to the records. Written consent of the patient must be presented as authority for release of identifiable medical information.<sup>11</sup>

<sup>1</sup>MONT. REV. CODES ANN. § 93-701-4(4) (1963).

<sup>2</sup>MONT. R. CIV. P. 35(b)(2) (Supp. 1971).

<sup>3</sup>MONT. REV. CODES ANN. § 93-701-4(7) (Supp. 1971).

<sup>4</sup>MONT. REV. CODES ANN. § 66-3212 (Supp. 1971).

<sup>5</sup>*Hier v. Farmers Mut. Fire Ins. Co.*, 104 Mont. 471, 67 P.2d 831, 837 (1937).

<sup>6</sup>*State v. Campbell*, 146 Mont. 251, 405 P.2d 978, 984 (1965). Unlike the section covering physicians, the section creating a psychologist-client privilege is not expressly limited to civil actions.

<sup>7</sup>MONT. REV. CODES ANN. § 10-902 (1967).

<sup>8</sup>MONT. REV. CODES ANN. § 10-905 (1967).

<sup>9</sup>MONT. REV. CODES ANN. § 69-4604 (1969).

<sup>10</sup>MONT. REV. CODES ANN. § 69-4610 (Supp. 1971).

<sup>11</sup>Montana Board of Health Regulations § 31.106.

## NEBRASKA

### Physician-Patient Privilege

**Statutes:** Nebraska recognizes the physician-patient privilege,<sup>1</sup> but the privilege is deemed to have been waived, as to both the testimony of a physician and hospital records, if the patient files an action (1) seeking to recover damages for personal injuries or (2) in which his physical or mental condition is an issue.<sup>2</sup> The privilege may also be waived by the bringing of a similar action by the personal representative of a deceased person.<sup>3</sup>

**Case Law:** The Eighth Circuit permitted an insurance company which received authorization from patients to inspect hospital records unless the patient's doctor, in the exercise of good faith judgment, certified under oath that the records should not be released, in the best interests of the patient's health.<sup>4</sup> The court held that the physician-patient privilege was waived by the patient's authorization.

### Public Record Acts

**Statute:** Nebraska gives citizens the right to examine public records unless otherwise provided by



law.<sup>5</sup> There does not appear to be an exception made for hospital records in Nebraska's statutes or regulations.

### Medical Lien Acts

Statutes: Nebraska's hospital lien law does not provide for the inspection of hospital records.<sup>6</sup>

### Required Reports

Statutes: Nebraska requires physicians to test pregnant women for syphilis.<sup>7</sup> Nebraska does not appear to require reports of battered children, tuberculosis, or venereal disease.

<sup>1</sup>NEB. REV. STAT. § 25-1206 (1964).

<sup>2</sup>NEB. REV. STAT. § 25-1207 (1964).

<sup>3</sup>*Id.*

<sup>4</sup>Bishop Clarkson Memorial Hosp. v. Reserve Life Ins. Co., 350 N.W.2d 1006 (8th Cir. 1966).

<sup>5</sup>NEB. REV. STAT. § 84-712 (1966).

<sup>6</sup>NEB. REV. STAT. §§ 52-401 to -402 (1968).

<sup>7</sup>NEB. REV. STAT. § 71-1117 (1971).

## NEVADA

### Physician-Patient Privilege

Statute: A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications among himself, his doctor or persons who are participating in the diagnosis or treatment under the direction of the doctor, including members of the patient's family.<sup>1</sup> The privilege may be claimed by the patient, but by the doctor only on behalf of the patient.<sup>2</sup> There is no privilege (1) in proceedings to hospitalize for mental illness, (2) for court-ordered examinations, or (3) where the condition of the patient is an element of a claim or defense.<sup>3</sup>

Records of treatment of narcotic addicts are privileged.<sup>4</sup>

### Public Record Acts

Statute: Public records act allows the inspection of records "the contents of which are not otherwise declared by law to be confidential."<sup>5</sup>

### Medical Lien Acts

Statute: Party against whom a claim is asserted has the right to examine and make copies of the records connected to the hospitalization of the injured person.<sup>6</sup>

### Required Reports

Statute: Suspected cases of child abuse must be reported,<sup>7</sup> and such reports are admissible in

evidence regardless of whether they would otherwise be privileged.<sup>8</sup> Reports of cases of venereal disease are not required to include the name of the patient.<sup>9</sup> Reports must also be made of cases of communicable disease<sup>10</sup> and epilepsy.<sup>11</sup>

### Special Access Laws

Statute: Records of persons hospitalized in a public hospital for mental illness shall be made available, upon the person's written authorization, to his attorney or personal physician.<sup>12</sup>

<sup>1</sup>NEV. REV. STAT. §§ 49.215-245 (1971). § 49.215 includes psychologists.

<sup>2</sup>NEV. REV. STAT. § 49.235 (1971).

<sup>3</sup>NEV. REV. STAT. § 49.245 (1971).

<sup>4</sup>NEV. REV. STAT. § 453.720 (1971).

<sup>5</sup>NEV. REV. STAT. § 239.010(1) (1971).

<sup>6</sup>NEV. REV. STAT. § 108.640 (1971).

<sup>7</sup>NEV. REV. STAT. § 200.502 (1971).

<sup>8</sup>NEV. REV. STAT. § 200.506 (1971).

<sup>9</sup>NEV. REV. STAT. § 441.110 (1971).

<sup>10</sup>NEV. REV. STAT. § 439.210 (1971).

<sup>11</sup>NEV. REV. STAT. § 439.270 (1971).

<sup>12</sup>NEV. REV. STAT. § 433.721 (1971).

## NEW HAMPSHIRE

### Physician-Patient Privilege

Statute: In 1969 New Hampshire enacted a privileged communications statute which places the privilege between a physician or surgeon and his patient on the same basis as the attorney-client privilege.<sup>1</sup> A separate statute creates a parallel privilege between psychologist and client.<sup>2</sup>

### Public Record Acts

Statute: Medical records are exempt from the disclosure provisions relating to public records.<sup>3</sup>

<sup>1</sup>N.H. REV. STAT. ANN. § 329:26 (Supp. 1971).

<sup>2</sup>N.H. REV. STAT. ANN. § 330-A:19 (Supp. 1971).

<sup>3</sup>N.H. REV. STAT. ANN. § 91-A:5 (Supp. 1971).

## NEW JERSEY

### Physician-Patient Privilege

Statute: The confidential communications statute in New Jersey prevents a witness from disclosing a communication, if the privilege is claimed and if the judge finds, *inter alia*, that the communication was a confidential one between patient and physician.<sup>1</sup> The privilege applies in civil and criminal actions, including juvenile delinquency proceedings. There are numerous exceptions created by subsequent statutes, including the following:

- 1. actions to commit a patient to a mental hospital
- 2. action in which the patient seeks to establish his competence
- 3. actions to recover damages on account of the criminal conduct of the patient
- 4. actions contesting the validity of wills
- 5. actions in which the condition of the patient is an element of the claim or defense
- 6. information which the physician or the patient is required to report to public officials
- 7. actions where the services of the physician were obtained to aid the commission of a crime or tort or to escape detection.

The statute also makes provisions for the disclosure of information by hospital utilization review committees.

Case Law: This statute applies to hospital records.<sup>2</sup> A 1969 case held that in a custody proceeding the plaintiff's motion to inspect medical records would be denied under the statutory privilege, except to the limited extent that the records could be subpoenaed for inspection by the court.<sup>3</sup> The provision of the statute which exempts from the privilege hospital records in an action to commit the patient to a mental hospital does not operate to remove from the privilege records of hospitalization which resulted from commitment proceedings, where there is an attempt to use such records in subsequent unrelated litigation.<sup>4</sup>

Public Record Acts

Statute: Any person against whom a claim is asserted for compensation or damages for personal injuries or death resulting from personal injuries, either under the Workmen's Compensation Act or at law, or his insurance carrier may examine hospital records in reference to such person.<sup>5</sup>

Any person who has been injured or his legal representative who has asserted or will assert a claim has the same right of examination of hospital records. These provisions apply to the attorneys of the respective parties as well, subject to reasonable rules promulgated by the hospital. There is to be no liability for permitting such examination.

Medical Lien Act

Statute: In New Jersey hospitals and nursing homes must allow any persons legally liable for a lien or against whom a claim for damages for injuries is asserted, to inspect records.<sup>6</sup> Failure to allow such examination is a valid defense in an action brought to enforce the lien.

Special Access Laws

Regulations: *Mental patients:* Medical records identifying any individual presently or formerly

receiving services in a non-correctional state institution are confidential and may not be disclosed. Exceptions:

- 1. Consent of individual
- 2. necessity
- 3. court directive

The statute provides that upon inquiry, information as to the patient's medical condition may be given to a relative, friend, patient's physician or attorney, if it appears that the information is to be used directly or indirectly for the benefit of the patient. N.J. STAT. ANN. § 30: 4-24.3 (Supp. 1971)

<sup>1</sup>N.J. REV. STAT. §§ 2A: 84A-22.2-.9 (Supp. 1971).

<sup>2</sup>Unick v. Kessler Memorial Hosp., 107 N.J. Super. 121, 257 A.2d 134 (1969).

<sup>3</sup>D. v. D., 108 N.J. Super. 149, 260 A.2d 255 (1969).

<sup>4</sup>*Id.*

<sup>5</sup>N.J. REV. STAT. §§ 2A: 82-41 to 45 (1952). See also N.J. REV. STAT. §§ 47: 1A-1 *et seq.* (Supp. 1972), which provides that public records are open for inspection by the general public, with certain exceptions for the protection of public interest.

<sup>6</sup>N.J. REV. STAT. §§ 2A: 44-45 (Supp. 1971).

NEW MEXICO

Physician-Patient Privilege

Statutes: Privilege applies only to communications with reference to venereal or loathsome disease and to communications with personal physicians in workmen's compensation cases.<sup>1</sup>

Privilege may be waived if person offers himself as a witness and voluntarily testifies as to such communications.<sup>2</sup>

Privilege extends to psychologist-client communications.<sup>3</sup>

Information of drug violations obtained by drug abuse rehabilitation facilities is not subject to disclosure.<sup>4</sup> However, information communicated to physicians in an effort to procure unlawfully narcotic drugs is not privileged.<sup>5</sup>

Unprofessional or dishonorable conduct includes, among other things, wilfully or negligently divulging a professional secret.<sup>6</sup>

Public Records Acts

Statute: Open records act expressly exempts medical records.<sup>7</sup>

All health information that identifies specific individuals as patients is strictly confidential and shall not be a matter of public record or accessible to the public even though contained in the records of governmental agency.<sup>8</sup>

Required Reports

Statute: Venereal disease reports are not required to include names: information and reports are confidential and inaccessible to the public.<sup>9</sup>

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## Special Access Laws

Statute: Disclosure of records of mental patients is not allowed except upon the consent of the patient or as a court may direct.<sup>10</sup>

Regulations: "In practice, information is released only with the consent of the patient."<sup>11</sup>

<sup>1</sup> N.M. STAT. ANN. § 20-1-12(d) (1970).

<sup>2</sup> N.M. STAT. ANN. § 20-1-12(f) (1970).

<sup>3</sup> N.M. STAT. ANN. § 67-30-17 (Supp. 1971).

<sup>4</sup> N.M. STAT. ANN. § 54-10-13 (Supp. 1971).

<sup>5</sup> N.M. STAT. ANN. § 54-7-44 (1962).

<sup>6</sup> N.M. STAT. ANN. § 67-5-9(5) (Supp. 1971).

<sup>7</sup> N.M. STAT. ANN. § 71-5-1 (1961).

<sup>8</sup> N.M. STAT. ANN. § 12-18-1 (Supp. 1971).

<sup>9</sup> N.M. STAT. ANN. § 12-3-5 (1968).

<sup>10</sup> N.M. STAT. ANN. § 32-2-18 (1953).

<sup>11</sup> Letter from Julia C. Southerland, Chief Attorney, New Mexico Health and Social Services Department to the Task Force, June 13, 1972.

## NEW YORK

## Physician-Patient Privilege

Statutes: New York recognizes the privileged nature of information acquired by doctors, dentists and nurses in their professional capacity, and which was necessary to enable the practitioner to act in that capacity.<sup>1</sup> The privilege can be waived by the patient.

Information privileged under the statute can be disclosed after the patient's death, except that the privilege remains in force for information that would tend to disgrace the memory of the patient. The privilege can be waived by the deceased patient's surviving spouse, personal representative, or next of kin.<sup>2</sup>

Case Law: The privilege cannot be claimed by a party for a non-party patient.<sup>3</sup>

The New York Court of Appeals recently held that the privilege of a patient is waived by the bringing or defending of a personal injury action in which the physical or mental condition of the patient is affirmatively put in issue.<sup>4</sup> However, a defendant does not put his condition in issue merely by denying the allegations of the complaint.

## Medical Lien Acts

Statutes: The New York hospital lien law does not provide for the inspection of hospital records.<sup>5</sup>

## Required Reports

Statutes: New York law requires physicians to report cases of venereal disease,<sup>6</sup> tuberculosis,<sup>7</sup> and child abuse.<sup>8</sup>

## Special Access Laws

Statutes: When a subpoena *duces tecum* which requires the production of medical records is served upon a hospital, city or state department, a transcript or copy certified as correct may be produced unless otherwise ordered by a court.<sup>9</sup>

After an action is begun in which the mental or physical condition of a party, agent, employee, etc., is in controversy, any party may serve notice on another party to submit to a physical or mental examination. The notice may require duly executed and acknowledged written authorizations permitting all parties to obtain and make copies of records of specified hospitals relating to the mental or physical condition in controversy. A party who obtains a copy of a hospital record as a result of the authorization of another party is required to deliver a duplicate to that party.<sup>10</sup>

Case Laws: The New York Supreme Court has held that the physical or mental condition of a party must merely be in controversy to obtain an examination and records; it does not have to be in issue.<sup>11</sup>

A hospital cannot withhold a patient's records to prevent him from discovering the identity of the doctors who operated on or treated him.<sup>12</sup>

Regulations: Regulations allow hospitals to establish procedures governing the release of information from patients' medical records.<sup>13</sup>

<sup>1</sup> N.Y. CIV. PRAC. LAW § 4504(a) (McKinney Supp. 1971).

<sup>2</sup> N.Y. CIV. PRAC. LAW § 4504(c) (McKinney Supp. 1971).

<sup>3</sup> *People v. Preston*, 176 N.Y.S.2d 542 (Kings County Ct. 1958).

<sup>4</sup> *Koump v. Smith*, 25 N.Y.2d 287, 250 N.E.2d 857, 303 N.Y.S.2d 858 (1969).

<sup>5</sup> N.Y. LIEN LAW § 189 (McKinney 1966).

<sup>6</sup> N.Y. PUB. HEALTH LAW § 2300 (McKinney 1971).

<sup>7</sup> N.Y. PUB. HEALTH LAW § 2221 (McKinney 1971).

<sup>8</sup> N.Y. SOC. SERV. LAW § 383a (McKinney Supp. 1972).

<sup>9</sup> N.Y. CIV. PRAC. LAW § 2306(a) (McKinney 1963).

<sup>10</sup> N.Y. CIV. PRAC. LAW § 3121 (McKinney 1963).

<sup>11</sup> *Fisher v. Fossett*, 45 Misc.2d 757, 257 N.Y.S.2d 821 (Sup. Ct. 1965).

<sup>12</sup> *Application of Weiss*, 208 Misc. 1010, 147 N.Y.S.2d 455 (Sup. Ct. 1955).

<sup>13</sup> 10 Official Compilation of Codes, Rules and Regulations § 720.20(p) (1971).

## NORTH CAROLINA

## Physician-Patient Privilege

Statute: Information acquired in treating patients is privileged from disclosure except that the court, either prior to or at trial, may compel disclosure if necessary to a proper administration of justice.<sup>1</sup>

There is a statutory exception for child abuse cases.<sup>2</sup>

The privilege has been extended to cover psychologist-client communications.<sup>3</sup>

Information pertaining to treatment of drug dependant persons is confidential and inadmissible in evidence.<sup>4</sup>

Case Law: Privilege may be waived by patient but not by doctor.<sup>5</sup> Privilege may also be waived by patient's testifying in great detail as to his physical condition.<sup>6</sup>

Regulations:—

## Public Record Acts

Statute: Public records inspection statute does not expressly exempt medical records.<sup>7</sup> However, the Attorney General, in a letter responding to an inquiry from a state health official, stated that it was his opinion that the compiling of clinical records does not constitute "transaction of public business" within the meaning of the statute and that such records should not be made available for public inspection.<sup>8</sup>

## Required Reports

Statutes: Abortions are to be reported, but such reports are for statistical purposes only and confidentiality of patient relationship is to be protected.<sup>9</sup>

Reports of cancer<sup>10</sup> venereal disease<sup>11</sup> and bites of rabid dogs are also required.

## Special Access Laws

Statute: Records of mental patients are not to be disclosed except upon court order.<sup>13</sup>

Regulations: Hospital records may not be taken from a hospital except under a subpoena.<sup>14</sup>

in the course of his professional employment.<sup>1</sup> This statement of the physician-patient privilege is similar to the language used in many other states and it presumably applies to hospital records.

North Dakota law also provides that the privilege is waived if a person (patient) testifies as a witness to a subject privileged under the physician-patient privilege.<sup>2</sup>

## Public Record Acts

Statutes: Hospital records are not specifically excluded from the statute giving the public access to records,<sup>3</sup> but the regulations governing hospital records<sup>4</sup> may come within the wording of the statute "except as otherwise specifically provided by law" and bar access to records of public hospitals.

## Medical Lien Acts

Statutes: The North Dakota hospital lien act allows inspection of hospital records by the party against whom the lien is asserted, i.e., the defendant.<sup>5</sup>

## Required Reports

Statutes: North Dakota law requires physicians to report cases of venereal disease<sup>6</sup> and child abuse or neglect<sup>7</sup> and provides that evidence disclosed in the latter type of report is not privileged.

## Special Access Laws

Regulations: State Hospital Regulations state that medical records shall be confidential, that only authorized personnel shall have access to the records, that written consent of the patient shall be presented for release of medical information and that hospital records generally should not be removed from the "hospital environment" except by subpoena.<sup>8</sup>

<sup>1</sup>N.C. GEN. STAT. § 8-53 (1969).  
<sup>2</sup>N.C. GEN. STAT. § 8-53.1; § 110-121 (Supp. 1971).  
<sup>3</sup>N.C. GEN. STAT. § 8-53.3 (Supp. 1971).  
<sup>4</sup>N.C. GEN. STAT. § 90-109.1(a) (Supp. 1971).  
<sup>5</sup>Yow v. Pittman, 241 N.C. 69, 84 S.E.2d 297, 298 (1954).  
<sup>6</sup>Capps v. Lynch, 253 N.C. 18, 116 S.E.2d 137, 142 (1960).  
<sup>7</sup>N.C. GEN. STAT. § 132-1, -6 (1964).  
<sup>8</sup>Letter from George B. Patton, Attorney General of North Carolina, to Dr. O. David Garvin, District Health Officer, Chapel Hill, N.C., in response to letter dated Feb. 13, 1958.  
<sup>9</sup>N.C. GEN. STAT. § 14-45.1 (Supp. 1971).  
<sup>10</sup>N.C. GEN. STAT. § 130-184 (1964).  
<sup>11</sup>N.C. GEN. STAT. § 130-95 (1964).  
<sup>12</sup>N.C. GEN. STAT. § 106-380 (1966).  
<sup>13</sup>N.C. GEN. STAT. § 122-8.1 (1964).  
<sup>14</sup>N.C. Medical Care Comm'n, 14 Laws, Regulations and Procedures Applying to Licensing of Hospitals 39.

<sup>1</sup>N.D. CENT. CODE § 31-01-06(3) (Supp. 1972).

<sup>2</sup>N.D. CENT. CODE § 31-01-07 (1960).

<sup>3</sup>N.D. CENT. CODE § 44-04-18 (1960).

<sup>4</sup>See *infra*, note 8.

<sup>5</sup>N.D. CENT. CODE § 35-18-09 (1960).

<sup>6</sup>N.D. CENT. CODE § 23-07-02 (1960).

<sup>7</sup>N.D. CENT. CODE § 50-25-01 to -05 (Supp. 1971).

<sup>8</sup>Rules and Regulations for Hospitals and Related Institutions. R 23-16-8 A.1-3.

## NORTH DAKOTA

### Physician-Patient Privilege

Statutes: A physician cannot be examined as to information acquired in attending the patient or as to any communication made by the patient to him

## OHIO

### Physician-Patient Privilege

Statutes: Ohio recognizes the physician-patient privilege, which may be waived by the express consent of the patient, a surviving spouse or



personal representative, or by the voluntary testimony of the patient.<sup>1</sup>

**Case Law:** The Ohio Supreme Court has held<sup>2</sup> that the physician-patient privilege must be strictly construed since it is in derogation of the common law. Only communications between a physician and patient, not in the presence of a third person, are to be considered privileged communications.

A defendant may not inspect plaintiff's hospital records over plaintiff's objection of privilege by taking the deposition of the record librarian because the question of what portion of a hospital record is privileged and what is not is a judicial determination beyond the capabilities of a notary.<sup>3</sup>

Plaintiff was ordered before trial to produce records of doctors in her possession or which would come into her possession before trial if plaintiff contemplated waiver of her physician-patient privilege.<sup>4</sup>

However the Ohio Supreme Court recently held that a personal injury litigant does not waive the physician-patient privilege merely by filing his petition and that a court cannot compel disclosure of personal medical records.<sup>5</sup>

A lower court later held that the physician-patient privilege does not apply in malpractice cases.<sup>6</sup>

Thus, some portions of the hospital record are privileged, but it is not clear from the cases how the determination of privilege is to be made.

#### Public Record Acts

**Statutes:** Ohio law provides for state and county record departments, but excludes records of county hospitals from the records covered.<sup>7</sup>

#### Required Reports

**Statutes:** Ohio requires physicians and others to report cases of child abuse.<sup>8</sup>

#### Special Access Laws

**Case Law:** The Supreme Court has held that when a request is made to inspect hospital records, the hospital may permit a former patient to see as much of his records as the hospital deems to be in the beneficial interest of the patient. If unsatisfied, the patient may commence an action to require the furnishing of the entire record.<sup>9</sup>

<sup>1</sup> OHIO REV. CODE ANN. § 2317.02(A) (Page 1954).

<sup>2</sup> *Weis v. Weis*, 147 Ohio St. 416, 72 N.E.2d 245 (1947).

<sup>3</sup> *Heinemann v. Mitchell*, 8 Ohio Misc. 390, 220 N.E.2d 616 (Ct. C.P. Hamilton County 1964).

<sup>4</sup> *Greene v. Sears, Roebuck & Co.*, 40 F.R.D. 14 (N.D. Ohio 1966); *Lambdin v. Leonard*, 20 Ohio Misc. 189, 251 N.E.2d 165 (Ct. C.P. Montgomery County 1968), *rev'd sub. nom. State ex rel. Lambdin v. Benton*, 21 Ohio St.2d, 254 N.E.2d 681 (1970).

<sup>5</sup> *State ex rel. Lambdin v. Benton*, 21 Ohio St.2d 254 N.E. 2d 681 (1970).

<sup>6</sup> *Otto v. Miami Valley Hosp. Soc'y*, 26 Ohio Misc. 72, 166 N.E.2d 270 (Ct. C.P. Montgomery County 1971).

<sup>7</sup> OHIO REV. CODE ANN. § § 149.32-40 (Page 1969).

<sup>8</sup> OHIO REV. CODE ANN. § 2151.42.1 (Page 1968).

<sup>9</sup> *Wallace v. University Hosps.*, 171 Ohio St. 487, 172 N.E.2d 459 (1961).

## OKLAHOMA

### Physician-Patient Privilege

**Statutes:** Physician is incompetent to testify in civil and criminal actions with reference to patient's communications or knowledge obtained by personal examination of the patient. The privilege is waived if the party offers himself or physician as a witness.<sup>1</sup>

Under the rules of Civil Procedure a party can get a copy of the report of an examination required by an adverse party without having to turn over all other pertinent medical records as to the condition examined.<sup>2</sup>

Unprofessional conduct is defined as, in part, wilfully betraying a professional secret to the detriment of the patient.<sup>3</sup>

All communications relating to the treatment of drug dependents are confidential.<sup>4</sup>

**Case Law:** A party does not waive the privilege by placing in issue his own physical condition.<sup>5</sup>

### Public Record Acts

**Statute:** Statute permitting public inspection of public records does not apply to "other records required by law to be kept secret."<sup>6</sup>

### Required Reports

**Statute:** Physicians are required to report cases of child abuse<sup>7</sup> and privilege does not affect admissibility of such reports.<sup>8</sup> Cases of venereal disease must also be reported, but such reports are inaccessible to the public.<sup>10</sup>

### Special Access Laws

**Statute:** Case records of former medical patients may, with the patient's consent, be furnished to community health services, social agencies and private physicians who are engaged in a therapeutic endeavor with the former patient.<sup>11</sup>

**Case Law:** Patient has property right in information appearing or portrayed on hospital records and he, or those authorized by him, is entitled to make such inspection and/or copy such records without resort to litigation.<sup>12</sup>

<sup>1</sup> OKLA. STAT. ANN. tit. 12, § 385 (6) (1960).

<sup>2</sup> OKLA. STAT. ANN. tit. 12, § 425 (Supp. 1971).

<sup>3</sup> OKLA. STAT. ANN. tit. 43A, § 657 (Supp. 1971).

<sup>4</sup> OKLA. STAT. ANN. tit. 59, § 509 (Fourth) (1971).

<sup>5</sup> *Avery v. Nelson*, 455 P.2d 75, 78 (1969).

<sup>6</sup> OKLA. STAT. ANN. tit. 51, § 24 (1960).



<sup>7</sup>OKLA. STAT. ANN. tit. 21, § 846 (Supp. 1971).<sup>8</sup>OKLA. STAT. ANN. tit. 21, § 848 (Supp. 1971).<sup>9</sup>OKLA. STAT. ANN. tit. 63, § 1-528(b) (1964).<sup>10</sup>OKLA. STAT. ANN. tit. 63, § 1-532 (1964).<sup>11</sup>OKLA. STAT. ANN. tit. 43A, § 18 (13) (Supp. 1971).<sup>12</sup>Pyramid Life Ins. Co. v. Masonic Hosp. Ass'n, 191 F.Supp. 51,54 (1961).

## OREGON

## Physician-Patient Privilege

Statute: Physician may not be examined in a civil action, without the consent of his patient, as to information acquired in attending patient.<sup>1</sup> Privilege is waived if party offers himself as a witness.<sup>2</sup>

Psychologist cannot be examined without the consent of his patient as to any communications made by his client to him or advice given by him in the course of professional employment.<sup>3</sup>

Case Law: Physician-patient privilege is not applicable to criminal proceedings.<sup>4</sup>

A party does not waive privilege by filing an action for personal injuries or when called involuntarily to testify at trial or on deposition.<sup>5</sup>

Other: "No lawyer should request and no physician should furnish any information concerning the history, physical condition, diagnosis or prognosis of a patient except upon written authorization of the patient."<sup>6</sup>

## Medical Lien Acts

Statute: Any party legally liable or against whom a claim has been asserted may examine and make copies of hospital records in reference to the hospitalization of the injured person.<sup>7</sup>

## Required Reports

Statute: Physicians are required to report cases of injuries suspected to be caused by violence;<sup>8</sup> such reports are confidential and not accessible for public inspection.<sup>9</sup>

## Special Access Laws

Regulations: Medical records are the property of the hospital and shall not be removed except where necessary for a judicial or administrative proceeding.<sup>10</sup>

## PENNSYLVANIA

## Physician-Patient Privilege

Statute: Under the Pennsylvania privileged communications statute, which applies only in civil cases, physicians and surgeons may not disclose any information acquired in attending the patient in a professional capacity, which tends to blacken the character of the patient, without the patient's consent.<sup>1</sup> However, the privilege is inapplicable in civil actions brought by the patient to recover damages for personal injuries.

Case Law: Hospital records on therapeutic abortion contain privileged communications within the meaning of the statute and can not be divulged without the consent of the parties affected.<sup>2</sup>

## Required Reports

Statutes: Physicians must report cases of contagious diseases.<sup>3</sup>

## Special Access Laws

Case Law: In a 1962 case, the court condemned the action of a physician in submitting a report on the plaintiff-patient to a doctor employed by her antagonist in litigation.<sup>4</sup>

Regulations: The topic of discovery and access to medical records appears primarily to be controlled by the Pa. Rules of Civil Procedure. Hospital records are within the scope of Rule 4009—right to inspection, *Yankovich v. Dicks*, 14 Pa.D&C.2d 53 (1957). However, discovery of records may be restricted to the specific relevant parts. *Matychuck v. Purnell*, 11 Pa.D&C.2d 507 (1957). Discovery is of course subject to the limitation that records created in anticipation of litigation or in preparation for trial are not discoverable. Where the patient's sobriety or intoxication are at issue, relevant parts of hospital records may be inspected on motion of the plaintiff, *Rearick v. Griffith*, 27 Pa.D&C.2d 451 (1962). See also *Herman v. Daly*, 33 Pa.D&C.2d 164 (1964).

Mental patient situations have a special regulation. In general, records of those who are admitted or committed to mental institutions are open to inspection only to those persons designated by the director of the facility.<sup>5</sup>

<sup>1</sup>ORE. REV. STAT. § 44.040(1)(d) (1971).<sup>2</sup>ORE. REV. STAT. § 44.040(2) (1971).<sup>3</sup>ORE. REV. STAT. § 44.030(h) (1971).<sup>4</sup>State v. Betts, 235 Ore. 127, 384 P.2d 193 (1963).<sup>5</sup>Nielson v. Bryson, 477 P.2d 714 (Ore. 1970).<sup>6</sup>State Bar Association and Oregon State Medical Society, "Statement of Principles Governing Certain Physician-Lawyer Relationships."<sup>7</sup>ORE. REV. STAT. § 441.510 (1971).<sup>8</sup>ORE. REV. STAT. § 146.750 (1971).<sup>9</sup>ORE. REV. STAT. § 146.780(2) (1971).<sup>10</sup>Oregon Administrative Rules ch. 33 § 3-190(11) (1972).<sup>1</sup>PA. STAT. ANN. tit. 28, § 328 (1958).<sup>2</sup>*Beriman v. Duggan*, 119 P.J.L. 272, 1971 (case not available, case cited from PA. STAT. ANN. tit. 28, § 328 [Supp. 1972].)<sup>3</sup>PA. STAT. ANN. tit. 53, § 24663 (1957).<sup>4</sup>*Alexander v. Knight*, 197 Pa. Super. 79, 177 A.2d 142 (1962).<sup>5</sup>PA. STAT. ANN. tit. 50, § 4602 (1969), see also, PA. STAT. ANN. tit. 50, § 4605 (5), which makes it unlawful for any person to disclose without authority the contents of any persons, admitted or committed.

## RHODE ISLAND

## Medical Lien Acts

Statute: Under Rhode Island law, any person, firm, or corporation legally liable for a hospital lien or against whom a claim for compensation for injuries are asserted, may examine hospital records in reference to treatment, care and maintenance.<sup>1</sup>

## Required Reports

Statutes: Physicians must file reports of all cases of occupational diseases.<sup>2</sup>

## Special Access Laws

Regulations: Records are the property of the hospital. The institution may restrict the removal of the record from its premises subject to the intervention of the court. The patient has an undeniable right and interest in the contents of the record, although he may have to protect this interest through recourse to the courts.<sup>3</sup>

<sup>1</sup>R.I. GEN. LAWS ANN. § 9-3-7 (1969).

<sup>2</sup>R.I. GEN. LAWS ANN. § 23-5-5 (1969).

<sup>3</sup>Letter from Justice Joseph R. Weisberger, Superior Court of Rhode Island, to Dr. David L. Starbuck, M.D., Division of Epidemiology, Rhode Island State Department of Public Health, Sept. 9, 1971.

## SOUTH CAROLINA

## Physician-Patient Privilege

Case Law: In the absence of a statutory privilege, the common-law rule that there is no privilege prevails in this state.<sup>1</sup>

## Required Reports

Statute: Physicians are required to report cases of venereal disease<sup>2</sup> and other contagious diseases.<sup>3</sup>

## Special Access Laws:

Statutes: Records of mental patients are not to be disclosed except:

1. upon consent of the parent or guardian
2. upon court order
3. as necessary as cooperating with Federal agencies in furthering the welfare of the patient or his family
4. as necessary in cooperation with law enforcement agencies
5. when public safety is involved.<sup>4</sup>

Similar statutes govern disclosure of records of persons treated for alcoholism or drug addiction.<sup>5</sup>

Regulations: Hospital records of patients are the property of the institution and must not be taken from the hospital property except by court order.<sup>6</sup>

<sup>1</sup>Peagler v. Atlantic Coast Line R.R., 232 S.C. 274, 101 S.E. 2d 821, 825 (1958).

<sup>2</sup>S.C. CODE ANN. § 32-593 (Supp. 1971).

<sup>3</sup>S.C. CODE ANN. § 32-552 (Supp. 1971).

<sup>4</sup>S.C. CODE ANN. § 32-1022 (Supp. 1971).

<sup>5</sup>S.C. CODE ANN. § 32-995.18 (Supp. 1971).

<sup>6</sup>So. Carolina State Board of Health, *Minimum Standards for Licensing in South Carolina Hospitals*, §501.4 (1968).

## SOUTH DAKOTA

## Physician-Patient Privilege

Statute: South Dakota recognizes the physician-patient privilege which prohibits a physician from being examined in a civil action as to information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient without the consent of the patient.<sup>1</sup> Hospital records of a patient's diagnosis and treatment are considered an extension of the patient's privilege.<sup>2</sup>

Case Law: The Supreme Court of South Dakota has held that the physician-patient privilege is to be liberally construed in favor of the patient.<sup>3</sup>

## Medical Lien Laws:

Statutes: The Law in South Dakota provides for the inspection of hospital records.<sup>4</sup>

## Required Reports

Statutes: South Dakota requires physicians to report cases of venereal disease<sup>5</sup>, tuberculosis<sup>6</sup>, and child abuse<sup>7</sup>. Reports of the latter are not considered privileged communications.<sup>8</sup>

## Special Access Laws

Statutes: The legislature has put all hospitals under the jurisdiction of the State Department of Health and requires them to maintain records.<sup>9</sup> The legislature has also prohibited disclosure of information received by the Department of Health, except through judicial order or as otherwise provided by law.<sup>10</sup> Whether statutes make hospital records confidential is unclear.

<sup>1</sup>S.D. COMPILED LAWS ANN. § 19-2-3 (1967).

<sup>2</sup>Memorandum from Assistant Attorney General to the Secretary of State, at 3 (see appended material to this section).

<sup>3</sup>Hogue v. Massa, 80 S.D. 319, 123 N.W.2d 131 (1963).

<sup>4</sup>S.D. COMPILED LAWS ANN. § 44-12-9 (1967).

<sup>5</sup>S.D. COMPILED LAWS ANN. § 34-23-2 (1967).

<sup>6</sup>S.D. COMPILED LAWS ANN. § 34-22-25 (Supp. 1972).

<sup>7</sup>S.D. COMPILED LAWS ANN. § 26-10-10 (1967).

<sup>8</sup>S.D. COMPILED LAWS ANN. § 26-10-15 (1967).

<sup>9</sup>S.D. COMPILED LAWS ANN. § 34-12-15 (1967).

<sup>10</sup>S.D. COMPILED LAWS ANN. § 34-12-17 (1967).

## TENNESSEE

## Physician-Patient Privilege

**Statute:** A psychiatrist-patient privilege was enacted in 1965.<sup>1</sup> It does not apply in civil or criminal cases in which the mental condition of the patient is at issue or where the court determines that the privilege should be withheld in the interests of justice.

A chapter dealing with voluntary patients in mental hospitals provides that records made for the purpose of that chapter which directly or indirectly identify a patient or former patient are confidential. Exceptions are made for (1) consent of individual, (2) necessity, and (3) court directive. Disclosure of information as to the patient's medical condition may be made upon inquiry to the patient's family and friends.<sup>2</sup>

**Case Law:** There is no physician-patient privilege in Tennessee. Even if there were one relating to evidence at trial, it would have no bearing in a case where information was communicated out of court to a third party who, in the event of suit, would have had access to the report under discovery procedures anyway.<sup>3</sup>

## Public Record Acts

**Statute:** Medical records of patients in state hospitals and medical facilities and records of patients receiving state financial assistance are confidential and not open to public inspection.<sup>4</sup> Information is to be disclosed to the public only in compliance with a subpoena or court order.

## Special Access Laws

**Regulations:** Records are the property of the institution and are confidential.<sup>5</sup> They must not be removed from the institution and must remain confidential except by court order. However, excerpts may be routed to physicians or to institutions for consultation. Medical records are made available upon request to representatives of the Hospital Licensing Board or the State Department of Public Health.

<sup>1</sup>TENN. CODE ANN. § 24-112 (Supp. 1971).

<sup>2</sup>TENN. CODE ANN. § 33-1208 (Supp. 1971).

<sup>3</sup>Quarles v. Sutherland, 215 Tenn. 651, 389 S.W.2d 249 (1964).

<sup>4</sup>TENN. CODE ANN. § 15-305 (Supp. 1971).

<sup>5</sup>Tennessee Dept. of Pub. Health, Minimum Standards and Regulations for Hospitals § 801.3 (1966).

## TEXAS

## Medical Lien Acts

**Statute:** Under the Texas hospital lien law, persons against whom a claim for compensation for injuries

has been filed may examine hospital records in reference to the treatment, care and maintenance of the injured person.<sup>1</sup>

## Special Access Laws:

**Case Law:** In a 1970 malpractice action, a Texas court refused to permit plaintiff's counsel to examine county medical society records made six years after the surgery in question, on the grounds it was an attempt to inquire into irrelevant matters and to impeach the defendant-physician on collateral matters.<sup>2</sup>

**Regulations:** Regulations provide that the hospital owns the hospital records.<sup>3</sup> Although a signed authorization is preferred, the hospital may send records to another hospital or doctor caring for the patient without the patient's consent, but the hospital may be running the risk of a suit for breach of a confidential relationship or invasion of privacy. If there is a court order, of course, the patient's consent is not required. If the hospital is sued by the patient, the hospital may use the records in defense.

One article of the Texas law provides that hospital records of mental patients are confidential except in the following situations:

1. consent of the individual
2. necessity
3. court directive
4. chief administrator feels that it is the best interest of the patient to release the information.<sup>4</sup>

Information as to the patient's current condition may be disclosed to the family, relatives or friends of the patient.<sup>5</sup>

Records of persons applying for medical assistance are confidential,<sup>6</sup> as are records of any hospital committee.<sup>7</sup>

<sup>1</sup>TEX. REV. STAT. art. 5506a § 4a (1958).

<sup>2</sup>Goodnight v. Phillips, 458 S.W.2d 196 (1970).

<sup>3</sup>Letter enclosing pamphlet from Hal Nelson, Legal Consultant, Texas State Department of Health-Texas Hospital Association, June 13, 1972.

<sup>4</sup>TEX. REV. STAT. art. 5547-87 (1958).

<sup>5</sup>Id.

<sup>6</sup>TEX. REV. CIV. STAT. ANN. art. 695j-1 (Supp. 1972).

<sup>7</sup>TEX. REV. CIV. STAT. ANN. art. 4447d (Supp. 1972).

## UTAH

## Physician-Patient Privilege

**Statute:** A physician, without the consent of his patient, cannot be examined in a civil action as to information acquired in attending patient.<sup>1</sup>

A psychologist cannot be examined in a civil or criminal action as to information acquired in the course of his professional services.<sup>2</sup>



Information communicated to a physician in an effort to unlawfully procure a narcotic drug is not privileged.<sup>3</sup>

Unprofessional conduct is defined, in part, as willful betrayal or disclosure of professional secret or the violation of a privileged communication except as required by law.<sup>4</sup>

### Required Reports

Statute: Cases of suspected child abuse are required to be reported;<sup>5</sup> privilege does not apply to such reports.<sup>6</sup>

### Special Access Laws

Statutes: Hospital and physicians records are to be made available to any patient's attorney upon written authorization of the patient.<sup>7</sup>

Records of the patients in the state institutions are confidential and shall not be disclosed except as the patient or guardian shall consent or a court may direct.<sup>8</sup>

<sup>1</sup> UTAH CODE ANN. § 78-24-8(4) (1953).

<sup>2</sup> UTAH CODE ANN. § 58-25-9 (1963).

<sup>3</sup> UTAH CODE ANN. § 58-13a-36 (1963).

<sup>4</sup> UTAH CODE ANN. § 58-12-36 (Supp. 1971).

<sup>5</sup> UTAH CODE ANN. § 55-16-2 (Supp. 1971).

<sup>6</sup> UTAH CODE ANN. § 55-16-5 (Supp. 1971).

<sup>7</sup> UTAH CODE ANN. § 78-25-25 (Supp. 1971).

<sup>8</sup> UTAH CODE ANN. § 64-7-50 (1968).

## VERMONT

### Required Reports:

Statutes: Physicians must report cases of venereal disease to the Commissioner of Health.<sup>1</sup> Such reports are confidential. Vermont also has various provisions requiring physicians, health officers, and other persons to report cases of certain other diseases, including communicable diseases<sup>2</sup> and tuberculosis.<sup>3</sup>

### Special Access Laws:

Regulations: All information as to personal facts and circumstances obtained in connection with the administration of the Vermont State Health Department is confidential and considered privileged communications and is not to be disclosed without the consent of the individual concerned.<sup>4</sup> However, the regulation does not prohibit:

1) a disclosure of confidential information in summary, statistical, or other form which does not identify particular individuals, or

2) disclosure after consent by the Commissioner of such confidential information to other agencies or individuals, public or private, that are providing needed services to individuals. Only such information shall be released as is necessary to

achieve the specific purposes for which the disclosure is authorized and after the individual or agency receiving such information has agreed to safeguard the confidential nature of the released information.

<sup>1</sup> VT. STAT. ANN. tit. 18 § § 1092, 1093, and 1099 (1968).

<sup>2</sup> VT. STAT. ANN. tit. 18 § § 1001-07 (1968).

<sup>3</sup> VT. STAT. ANN. tit. 18 § § 1041, 1048 (Supp. 1971).

<sup>4</sup> Vermont Board of Health, Confidentiality Regulation, March 21, 1957.

## VIRGINIA

### Physician-Patient Privilege

Statute: A physician or psychologist may not testify in a civil action without the consent of the patient except when the physical or mental condition of the patient is at issue or court deems disclosure necessary to the proper administration of justice. The privilege does not apply to communications in efforts to unlawfully procure narcotic drugs.<sup>1</sup>

Case Law: Subpoena duces tecum for medical reports should be ordered when physical condition of the patient is at issue.<sup>2</sup>

### Required Reports

Statutes: Cases of venereal disease<sup>3</sup> and communicable diseases<sup>4</sup> are required to be reported.

### Special Access Laws

Regulations: "Because of the fear of hospital personnel and physicians, patients are normally not permitted to see their medical records nor are personal representatives allowed to review or copy the records, unless litigation is undertaken.

This policy has been developed for the protection of the patient's privacy and confidentiality of the records, not fear for possible litigation."<sup>5</sup>

<sup>1</sup> VA. CODE ANN. § 8-289 (Supp. 1971).

<sup>2</sup> Portsmouth v. Cilumbrello, 204 Va. 11, 129 S.E.2d 31, 33-34 (1963).

<sup>3</sup> VA. CODE ANN. § 32-91 (1964).

<sup>4</sup> VA. CODE ANN. § 32-48 (1964).

<sup>5</sup> Letter from John W. Crews, Assistant Attorney General, Commonwealth of Virginia, to Task Force, June 13, 1972.

## WASHINGTON

### Physician-Patient Privilege

Statute: A physician cannot, without patient's consent, be examined in a civil action as to information acquired in attending a patient.<sup>1</sup>

In criminal prosecutions physicians and surgeons are protected from testifying as to confessions or information received from any defendant by virtue of their profession and character.<sup>2</sup>

Psychologist-client communications enjoy the same privilege as attorney-client.<sup>3</sup>

**Case Law:** Physician-patient privilege statute is applicable to criminal cases by virtue of another statute that provides that rules of evidence in civil actions apply to criminal prosecutions.<sup>4</sup>

The statute which gives the privilege to physicians in criminal prosecutions has reference to the protection of the physician only.<sup>5</sup>

Hospital records, insofar as they tend to disclose what the physician learned, are protected by privilege.<sup>6</sup>

The privilege is not waived by the institution of an action for personal injuries.<sup>7</sup> Nor is the privilege waived by plaintiff's testimony on pre-trial deposition as an adverse witness as to the nature and extent of the alleged injury.<sup>8</sup>

Whenever it becomes apparent that the plaintiff must decide in favor of waiver, waiver should not be delayed until the trial itself, but defendant is entitled to know in time to take the deposition of the physician and prepare to meet his testimony.<sup>9</sup>

#### Required Reports

Statutes: Washington requires physicians to report cases of child abuse<sup>10</sup> and makes them immune from civil liability for such reports.<sup>11</sup>

#### Special Access Laws

Regulations: Department of Health regulations pertaining to medical records are silent as to accessibility.<sup>12</sup>

<sup>1</sup> WASH. REV. CODE ANN. § 5.60.050 (1963).

<sup>2</sup> WASH. REV. CODE ANN. § 10.52.020 (1961).

<sup>3</sup> WASH. REV. CODE ANN. § 18.83.110 (Supp. 1971).

<sup>4</sup> *State v. Miller*, 105 Wash. 475, 178 P. 459, 460 (1919); *State v. Sullivan*, 160 Wash. Dec. 216, 373 P.2d 474, 479 (1962). Other states have interpreted the same two statutes to mean that the privilege is not applicable in criminal cases.

<sup>5</sup> 178 P. at 460.

<sup>6</sup> *Toole v. Franklin Investment Co.*, 158 Wash. 696, 291 P.2d 1101, 1102 (1962).

<sup>7</sup> *Bond v. Independent Order of Foresters*, 69 Wash. 879, 421 P.2d 351, 353 (1966).

<sup>8</sup> 421 P.2d at 354.

<sup>9</sup> *Phipps v. Sasser*, 74 Wash.2d 439, 445 P.2d 624, 628-29 (1968).

<sup>10</sup> WASH. REV. CODE ANN. § 26.44.030 (Supp. 1971).

<sup>11</sup> WASH. REV. CODE ANN. § 26.44.060 (Supp. 1971).

<sup>12</sup> WASH. ADMIN. CODE § 248-18-440 (Supp. 1971).

## WEST VIRGINIA

### Physician-Patient Privilege

Statute: Physician is incompetent to testify without patient's consent concerning any communications made to him by his patient which were necessary to enable him to prescribe and act for the patient.<sup>1</sup>

### Public Record Acts

Statute: When a state record is required by law to be treated in a confidential manner, its confidential nature shall be protected.<sup>2</sup>

### Required Reports

Statute: Cases of venereal disease (without names)<sup>3</sup>, communicable disease<sup>4</sup> and tuberculosis<sup>5</sup> are required to be reported.

### Special Access Laws

Regulations: State regulations governing hospital records are silent as to accessibility.<sup>6</sup>

<sup>1</sup> W.VA. CODE ANN. § 50-6-10 (1966).

<sup>2</sup> W.VA. CODE ANN. § 5-8-13 (1971).

<sup>3</sup> W.VA. CODE ANN. § 16-4-6 (1966).

<sup>4</sup> W.VA. CODE ANN. § 16-2A-5 (1966).

<sup>5</sup> W.VA. CODE ANN. § 26-5A-4 (1971).

<sup>6</sup> State Department of Health, *West Virginia Regulations and Law for Licensing Hospitals* § 601.3 (1969).

## WISCONSIN

### Physician-Patient Privilege

Statutes: The Wisconsin physician-patient privilege bars a physician from disclosing any information necessary to enable him to serve a patient which he may have acquired in attending the patient in a professional character. It is inapplicable, *inter alia*, in all actions against a physician for malpractice; with the express consent of the patient, or if deceased, his personal representative or the beneficiary of his insurance policy.<sup>1</sup>

**Case Law:** The Wisconsin Supreme Court has held that the statute disqualifying a physician from testifying to privileged matters is to be strictly construed.<sup>2</sup>

Recently, the same court narrowed the type of records that may be withheld on a claim of privilege, holding that the party claiming the privilege should not be the sole judge of what evidence is relevant.<sup>3</sup>

An Attorney General opinion stated that the privilege statute is for the benefit of the patient and may be waived only as provided. Also, after the



death of a patient, only the privileged parts of the records may not be released.<sup>4</sup>

### Public Record Acts

Statutes: The Wisconsin Public Record Statute<sup>5</sup> does not exclude hospital records, bringing up the question of whether public hospitals' records are subject to inspection.

### Medical Lien Acts

Statutes: The Wisconsin hospital lien law does not provide for the inspection of hospital records.<sup>6</sup>

### Required Reports

Statutes: Wisconsin law requires physicians to report venereal disease,<sup>7</sup> tuberculosis,<sup>8</sup> and child abuse.<sup>9</sup> As in most other states, child abuse reports are not privileged communications.<sup>10</sup>

### Special Access Laws

Statutes: A Wisconsin Statute provides that a court may order the plaintiff in a personal injury or malpractice suit to give to the defendant or any physician named in the order, an inspection of x-rays and hospital records concerning the injuries for which damages are claimed.<sup>11</sup>

The statute also requires anyone having custody of medical records or the like to permit a person authorized by the patient or, if deceased, his personal representative or the beneficiary of a life insurance policy, to inspect and copy the records.<sup>12</sup> Refusal to comply can subject the person refusing access to all reasonable and necessary costs of obtaining the copies and inspection plus not more than \$50 in attorney's fees. The statute is not applicable to state or county mental hospitals. Case Law: The Wisconsin Supreme Court has held that where a prior nervous condition was in question in the suit, an order for inspection of the records of prior psychiatric treatment must be issued.<sup>13</sup>

Recently the same court held that the refusal of a record custodian to permit inspection on presentation of an authorization signed by the beneficiary of a deceased patient's life insurance policy would not make the hospital and the librarian liable where there was no indication on the authorization that the signer was the beneficiary or the personal representative of the deceased patient.<sup>14</sup>

<sup>1</sup> WIS. STAT. ANN. § 885.21 (1957).

<sup>2</sup> Leusink v. O'Donnell, et al., 255 Wis. 627, 39 N.W.2d 675 (1949).

<sup>3</sup> Wilkins v. Durand, 47 Wis.2d 527, 177 N.W.2d 892 (1970).

<sup>4</sup> 1928 WIS. OP. ATT'Y GEN. 385.

<sup>5</sup> WIS. STAT. ANN. § 16.80 (1957).

<sup>6</sup> WIS. STAT. ANN. § 239.80 (Supp. 1972).

<sup>7</sup> WIS. STAT. ANN. § 143.07 (1957).

<sup>8</sup> WIS. STAT. ANN. § 143.06 (1957).

<sup>9</sup> WIS. STAT. ANN. § 48.981 (Supp. 1972).

<sup>10</sup> WIS. STAT. ANN. § 885.21(f) (1957).

<sup>11</sup> WIS. STAT. ANN. § 269.57(2)(a)(2) (Supp. 1972).

<sup>12</sup> WIS. STAT. ANN. § 269.57(4) (Supp. 1972).

<sup>13</sup> Thompson v. Roberts, 269 Wis. 472, 69 N.W.2d 482 (1955).

<sup>14</sup> Fanshaw v. Medical Protective Ass'n, 52 Wis.2d 834, 190 N.W.2d 155 (1971).

## WYOMING

### Physician-Patient Privilege

Statute: A physician may not testify concerning a communication made to him by his patient without the patient's consent; if the patient voluntarily testifies, the patient immediately waives the privilege as to the subject matter he addressed.<sup>1</sup>

Communications with psychologists are also privileged.<sup>2</sup>

Case Law: Physicians may not testify if their patient is not a party and is not present to object.<sup>3</sup>

### Public Record Acts

Statute: The right to public inspection is denied for medical, psychological or social data on individual persons.

### Required Reports

Statute: Reports are required for suspected cases of child abuse<sup>4</sup> to which the privilege does not apply<sup>5</sup>; and for cases of venereal disease<sup>6</sup> and communicable diseases.<sup>8</sup>

### Special Access Laws

Regulations: Hospital and medical regulations are confidential except insofar as guardian or parent consents to release or a court orders disclosure.<sup>9</sup>

<sup>1</sup> WYO. STAT. ANN. § 1-139(1) (1959).

<sup>2</sup> WYO. STAT. ANN. § 33-343.4 (Supp. 1971).

<sup>3</sup> Peters v. Campbell, 80 Wyo. 492, 345 P.2d 234 (1959).

<sup>4</sup> WYO. STAT. ANN. § 9-692.3(d)(i) (Supp. 1971).

<sup>5</sup> WYO. STAT. ANN. § 14-28.8 (Supp. 1971).

<sup>6</sup> WYO. STAT. ANN. § 14-28.12 (Supp. 1971).

<sup>7</sup> WYO. STAT. ANN. § 35-177 (Supp. 1971).

<sup>8</sup> WYO. STAT. ANN. § 35-172 (Supp. 1971).

<sup>9</sup> Letter from Wm. L. Kallal, Assistant Attorney General Wyoming, to the Task Force, June 15, 1972.

## Appendix

## GRAPHIC DISPLAY OF THE RESULTS OF STATE-BY-STATE STUDY

State	Physician-Patient Privilege	Record Acts	Hospital Lien Laws	Required Reports	Authorized Disclosure
ALABAMA	X			X	X
ALASKA	X	X			X
ARKANSAS	X	X			X
ARIZONA	X	X			X
CALIFORNIA	X	X		X	X
COLORADO	X	X	X	X	X
CONNECTICUT	X	X		X	X
DELAWARE	X			X	X
DISTRICT OF COLUMBIA	X		X		X
FLORIDA	X	X			X
GEORGIA	X	X		X	X
HAWAII	X			X	X
IDAHO	X			X	X
ILLINOIS	X		X	X	X
INDIANA	X	X	X	X	X
IOWA	X	X	X	X	
KANSAS	X			X	X
KENTUCKY	X				X
LOUISIANA	X	X			X
MAINE	X		X		X
MARYLAND	X	X	X		
MASSACHUSETTS	X		X	X	X
MICHIGAN	X			X	X
MINNESOTA	X			X	
MISSISSIPPI	X			X	X
MISSOURI	X				X
MONTANA	X			X	X
NEBRASKA	X	X		X	
NEVADA	X	X	X	X	X
NEW HAMPSHIRE	X			X	X
NEW JERSEY	X	X	X		
NEW MEXICO	X	X		X	X
NEW YORK	X			X	X
NORTH CAROLINA	X	X		X	X
NORTH DAKOTA	X	X	X	X	X
OHIO	X	X		X	X
OKLAHOMA	X	X		X	X
OREGON	X		X	X	X
PENNSYLVANIA	X			X	X
RHODE ISLAND			X	X	X
SOUTH CAROLINA	X			X	X
SOUTH DAKOTA	X	X	X	X	X
TENNESSEE	X	X			X
TEXAS			X		X
UTAH	X			X	X
VERMONT				X	X
VIRGINIA	X			X	X
WASHINGTON	X				X
WEST VIRGINIA	X	X		X	X
WISCONSIN	X	X	X		X
WYOMING	X	X		X	X

# The Diagnosis and Treatment of Dangerousness

HARRY L. KOZOL

Director of Psychiatry, Massachusetts Department of Mental Health;  
Director, Center for the Diagnosis and Treatment of Dangerous Persons,  
Bridgewater, Mass.

S.B., 1927, Harvard College; M.D., 1934, Harvard Medical School

RICHARD J. BOUCHER

Head Administrative Assistant to the Director, Center for  
the Diagnosis and Treatment of Dangerous Persons, Bridgewater, Mass.

RALPH F. GAROFALO

Deputy Director, Center for the Diagnosis  
and Treatment of Dangerous Persons, Bridgewater, Mass

A.B. (Psychology), 1959, University of Bridgeport; A.M. (Psychology), 1961,  
Boston University

*Dangerousness in criminal offenders can be reliably diagnosed and effectively treated with a recidivism rate of 6.1 per cent. We define dangerousness as a potential for inflicting serious bodily harm on another.*

*This is a report of a ten-year study involving 592 male convicted offenders. Most of the crimes that brought these offenders to our notice were sex offenses. Several were compounded by extreme violence including murder, manslaughter, assault with intent to kill, and assault with a dangerous weapon. The staff's initial diagnosis indicated that 304 of these persons were not dangerous, and they were released into the community after completing their sentences. Twenty-six (8.6 per cent) subsequently committed serious assaultive (dangerous) crimes.*

*The courts concurred in our diagnosis of dangerous in 226 cases and committed these offenders to our special "treatment" facility for an indeterminate period of one day to life. Following treatment for an average period of forty-three months, eighty-two patients were discharged on recommendation of the clinical staff. Of these, five (6.1 per cent) subsequently committed serious assaultive crimes, including one murder.*

*Forty-nine of the originally committed patients were released by court order against the advice of the clinical staff. Of these, seventeen (34.7 per cent) subsequently committed serious assaultive crimes, including two murders.*

*Criteria of dangerousness and guidelines for its prediction were elaborated. No tests or psychiatric examinations can dependably predict a probability of dangerous behavior in the absence of an actual history of a seriously violent assault on another person. The potential for dangerous behavior is relative and covers a wide spectrum, from the mildly dangerous to the extremely dangerous. We postulate that those elements of the personality which cause dangerous behavior are common to all classes of assaultive behavior and that there is no basic difference between the man who kills to rape and the one who kills to rob.*

*Treatment is primarily psychiatric. We consider claims for the efficacy of pharmacological and physiological measures to be unproven and even specious. Treatment involves individualization and socialization: the identification and dissipation of antisocial predatory elements of the personality and the mobilization and reinforcement of socially conformative elements of the personality.*

**D**ANGEROUSNESS as an attribute of human personality has long been a subject of concern to the law and of even more concern to the community. This is a report of ten-year experience in the diagnostic identification and treatment of the dangerous offender.

We define dangerousness as a potential for inflicting serious bodily harm on another. Failure to recognize this potential may result in tragedy; its erroneous imputation may result in unjust deprivation of liberty. Its exact determination is relevant to sentencing practices, to involuntary mental hospitalization, and to other dispositions following conviction; it is also germane to the issue of preventive detention.

Does psychiatry have the expertise to distinguish between those persons who are safe to be at large and those who are not? The traditional literature of psychiatry is strangely silent on this subject. Morris has reflected "on the sparse contribution that psychiatry has made to the problem of defining and treating the disturbed

and dangerous criminal."<sup>1</sup> Psychiatry's disciplines should provide more than average competence for predicting human behavior.

The need for reliable identification of the dangerous offender is obvious. The President's Commission on Law Enforcement and Administration of Justice has recognized "the necessity for identifying those dangerous or habitual offenders who pose a serious threat to the community's safety."<sup>2</sup> Wolfgang and Ferracuti describe and define the existence of a subculture of violence.<sup>3</sup> In his preface to both editions of the Model Sentencing Act, Murrah states that "prolonged incarceration is necessary for certain individuals whose behavior

1. Norval Morris, "Psychiatry and the Dangerous Criminal," *Southern California Law Review*, vol. 41, 1968, pp. 535-56.

2. President's Commission on Law Enforcement and Administration of Justice, *The Challenge of Crime in a Free Society* (Washington, D.C.: U.S. Government Printing Office, 1967), p. 180.

3. Marvin E. Wolfgang and Franco Ferracuti, *The Subculture of Violence* (London: Tavistock Publications, 1967).



ior patterns and personality make them highly dangerous to society" in order to protect society from their "premature release."<sup>4</sup> Commenting on traditional sentencing practices, Rector asserted that "the long sentences under such systems fail to protect the public because they are too imprecisely imposed, without knowledge of whether the really dangerous offenders are the ones receiving the long terms."<sup>5</sup>

The Model Penal Code of the American Law Institute authorizes lengthy imprisonment in cases where "the defendant is a dangerous, mentally abnormal person whose commitment for an *extended* term is necessary for the protection of the public."<sup>6</sup> The interpretation of this statement may raise some questions: Is there a difference between "a dangerous, mentally abnormal person" and a dangerous *normal* one? Or does the phrase "mentally abnormal" imply that any dangerous person is abnormal? In the former case, "commitment for an extended term" would require that the person be dangerous and *also* mentally abnormal. And what disposition is recommended for the dangerous *normal* person?

The first edition of the Council of Judges' Model Sentencing Act defines the dangerous offender as one who (a) has "inflicted or attempted to inflict serious bodily harm . . . and . . . is suffering from a severe personality disorder indicating a propensity toward criminal activity" or (b) has

been convicted of "a crime which seriously endangered the life or safety of another, has been previously convicted of one or more felonies not related to the instant crime as a single criminal episode, and the court finds that he is suffering from a severe personality disorder indicating a propensity toward criminal activity."<sup>7</sup> Questions may be raised about this definition. Does it exclude persons who have "inflicted or attempted to inflict serious bodily harm" or have "seriously endangered the life or safety of another" but are *not* "suffering from a severe personality disorder indicating a propensity toward criminal activity"?

#### Medicolegal Philosophy

Not all persons who inflict serious bodily harm on others do so again. The task is to distinguish between those who will and those who won't. In 1970 the District of Columbia enacted legislation that provides for pretrial detention of "a person charged with a dangerous crime if the government certifies . . . there is no condition or combination of conditions which will reasonably assure the safety of the community."<sup>8</sup> The

7. Council of Judges, National Council on Crime and Delinquency, *Model Sentencing Act*, 1963, § 5 (a) and (b). The corresponding provision in the revised edition is § 5, subdivisions 1 (a), 1 (b), and 1 (c).

8. District of Columbia Court Reform Act, Pub. L. No. 91-358, ch. 13, §§ 22-1322 (July 29, 1970). The Act defines "dangerous crime" as follows: "(a) Taking or attempting to take property from another by force or threat of force, (b) unlawfully entering or attempting to enter any premises adapted for overnight accommodation of persons or for carrying on business with the intent to commit an offense therein, (c) arson or attempted arson of any premises adaptable for overnight accommodation of persons for carrying on business, (d) forcible rape, or assault with intent to commit forcible rape, or (e) unlawful sale or distribution of a narcotic or

4. Alfred P. Murrah, "Preface to Model Sentencing Act" [1st ed.], *Crime and Delinquency*, October 1963, p. 340; 2nd ed., *supra*, p. 338.

5. Milton G. Rector, "A Revolutionary Revision of American Penal Law," *Crime and Delinquency*, October 1963, p. 337.

6. American Law Institute, *Model Penal Code* § 7.03 (3).



Justice Department has stated its intention to extend such pretrial detention throughout all federal jurisdictions.<sup>9</sup>

Dangerous person legislation, whether it governs sentencing practices, preventive detention, release from incarceration, or civil commitment, is based on society's right and power to protect itself. When legislation calls on psychiatry to assist the law in determining whether an individual is dangerous, it may be broadly construed as based on preventive medicine. Because of his malignant potential, the dangerous offender is considered a menace to the health

depressant or stimulant drug (as defined by an Act of Congress) if the offense is punishable by imprisonment for more than one year." The law also applies under special circumstances to "a person charged with a crime of violence." "The term 'crime of violence' means murder; forcible rape; carnal knowledge of a female under the age of sixteen; taking or attempting to take immoral, improper, or indecent liberties with a child under the age of sixteen years; mayhem; kidnapping; robbery; burglary; voluntary manslaughter; extortion or blackmail accompanied by threats of violence; arson; assault with intent to commit any of the foregoing offenses as defined by any Act of Congress or any state law if the offense is punishable by imprisonment for more than one year."

Some of these designated offenses clearly fall under the headings of both "dangerous" and "violence," which serves to doubly insure their application to a particular person. The inclusion of the crime of unlawful sale or distribution of a depressant or stimulant drug in the same category with such crimes as rape, arson, and robbery emphasizes the dragnet nature of this legislation. One may question the juxtaposition of "carnal knowledge of a female under the age of sixteen" and "taking or attempting to take immoral, improper, or indecent liberties with a child under the age of sixteen years" (without any allegation of the use of force or threats) with such violent crimes as murder, forcible rape, mayhem, kidnapping, voluntary manslaughter, etc.

9. *New York Times*, May 15, 1971, p. 1.

and well-being of prospective victims. Accordingly, he is isolated from society by imprisonment or hospitalization until he is considered to be no longer dangerous. Implicit in all such programs is the responsibility for treating the offender—a responsibility which, regrettably, is honored more in the breach than in the observance. The ultimate objective is to modify the offender's dangerous potential to insure that he will not repeat his offense.<sup>10</sup> All communities have witnessed the tragic repetition of vicious and even murderous offenses by men who have been released from prison after serving long sentences for identical or similar crimes.

According to virtually all dangerous-person legislation, an individual cannot be legally identified as dangerous until psychiatry has diagnosed him as such. The ALI Code states:

The Court shall not make such a finding unless the defendant has been subjected to a psychiatric examination resulting in the conclusions that his mental condition is gravely abnormal; that his criminal conduct has been characterized by a pattern of repetitive or compulsive behavior or by persistent aggressive behavior with heedless indifference to consequences; and that such condition makes him a serious danger to others.<sup>11</sup>

The Model Sentencing Act states that the convicted offender "shall be remanded to a diagnostic facility whenever, in the opinion of the court, there is reason to believe he falls within the category" of dangerous offenders.<sup>12</sup> A footnote states that the

10. Harry L. Kozol, Murray I. Cohen, and Ralph F. Garofalo, "Il Delinquente Sessuale Pericoloso in Senso Criminale," *Quarterly Journal of Clinical Criminology* (Rome), April-June 1966, p. 179.

11. *Model Penal Code* § 7.03(3).

12. *Model Sentencing Act* (1st ed., 1963), § 6. (The corresponding provision in the second edition is § 5, sub. 1, second paragraph.)

diagnostic facility should be "staffed by full-time psychiatric and other necessary personnel."<sup>13</sup>

More than half the jurisdictions in the United States have laws relating to dangerous criminal behavior. About twenty jurisdictions, including Massachusetts, which is the focus of this study, restrict the designation "dangerous" to sex offenders. Several states—notably Connecticut,<sup>14</sup> Maryland,<sup>15</sup> Minnesota,<sup>16</sup> and Ohio,<sup>17</sup>—have dangerous person statutes that apply to the perpetrator of any crime by designating as psychologically abnormal any offender who is dangerous or constitutes an "actual danger to society" or is a "menace"<sup>18</sup> to the safety of others. Restricting the designation "dangerous" to sex offenders probably reflects society's special sensitivity to and fascination with all things sexual. Guttmacher found it "far sounder psychiatrically to include the really serious sex offenders among the general group of dangerous offenders than to isolate them in a separate category . . . for the disposition and treatment of the dangerous sex offender need not differ radically from that of the more general group."<sup>19</sup> McGarry and Cotton have noted that "if such programs for the sexually dangerous are justified, it makes no sense to exclude the repetitively aggressive dangerous offender without sexual overtones."<sup>20</sup> Surely

the perpetrators of sadistically atrocious robberies and other crimes of personal violence may be as dangerous to the health and lives of their victims as any sex offenders. It is our hypothesis that there is no difference between the person who kills to rob and the person who kills to rape.

### Futility of Sentencing Practices

The Massachusetts statute relating to sexually dangerous persons<sup>21</sup> was enacted following the heinous murder of two small brothers by a man who had been released from prison only a few weeks earlier, having served part of a ten-year sentence for a nearly fatal sex assault on a young boy. Following are the facts and background of that case:

On October 9, 1950, fourteen-year-old Raymond Ohlsen intercepted two twelve-year-old boys who were hiking through an isolated section of a public park. He had removed the chain from his bicycle and pretended that it was broken. He asked one of the boys to go off to a distant service station to borrow a wrench. Threatening the remaining boy, Ohlsen forced him to take off his clothes and submit to some perverse sexual relations. When the youngster resisted, he clubbed him into unconsciousness, turned him over, and, after sodomizing the boy, tried to strangle him by twisting the bicycle chain around his neck. Frustrated in this by the rigidity of the chain, Ohlsen took the hunting knife that his unconscious victim was carrying, straddled the boy's prone body, and flipped the knife through the back of his chest three times, penet-

*vard Journal on Legislation*, vol. 6, 1969, p. 298.

21. Mass. Gen. Laws Ann. ch. 123A (1958); Mass. Gen. Laws Ann. amends. ch. 123A, § 2 (1959), ch. 123A, § 9 (1960), ch. 123A, § 9 (1966).

13. *Ibid.*

14. Conn. Gen. Stat. § 17-239 (1958).

15. Md. Code Ann. § 31B-5 (1957).

16. Minn. Stat. § 526.09 (1957).

17. Ohio Rev. Code Ann. § 2947.24(B) (Baldwin 1958).

18. *Supra* note 14; *supra* note 17; Wash. Rev. Code § 71.06.010 (1958).

19. Manfred S. Guttmacher, "Dangerous Offenders," *Crime and Delinquency*, October 1963, p. 383.

20. A. Louis McGarry and Raymond D. Cotton, "A Study in Civil Commitment: The Massachusetts Sexually Dangerous Act," *Har-*

ing the lungs and barely missing the heart. Then he fled. Fortunately the youngster survived.

Ohlsen was arrested and committed for psychiatric examination. The diagnosis was "without psychosis; psychopathic personality with asocial and amoral trends." The psychiatrists had equated committable mental illness with psychosis, and mental hospitalization was not recommended. Ohlsen was tried and convicted of assault with intent to kill and open and gross lewdness. On March 2, 1951, he was sentenced to serve ten years in prison, the maximum under the law. In prison he was generally well-behaved and considered to be a "good inmate." Parole was denied in 1956 when a psychiatrist predicted that he would commit another serious crime. None of the involved authorities saw fit to invoke the provisions of the new mental health law that was enacted on August 4, 1955. This law redefined committable mental illness to include "character disorder which renders [a person] so deficient in judgment or emotional control that he is in danger of causing physical harm to himself or to others. . . ."<sup>22</sup> Ohlsen could have been committed to a mental hospital for an indeterminate period at any time between the date of enactment of this new law and his release on June 7, 1957.

Exactly seven weeks after his release, Ohlsen intercepted two little brothers, aged ten and twelve, in a public park. He stabbed them and burned their bodies. Then nearly twenty-one years old, Ohlsen was charged with murder but has never been tried. Following arraignment he was again committed to a state hospi-

tal for diagnostic study. This time he was described as a "sadistic psychopath": the diagnosis was "schizoid personality with asocial and amoral trends." He was found to be "mentally ill by reason of deficient judgment and emotional control and in danger of doing harm to others." The same diagnosis would earlier have prevented his release and return to the community. Considered incompetent to stand trial, he was committed to the special state hospital for the criminally mentally ill until such time as he might be mentally competent to stand trial. He was subsequently diagnosed as "schizophrenic reaction, paranoid." His psychiatric condition has not improved and, if anything, has deteriorated. He remains incompetent to stand trial, and it is unlikely that he will ever be brought to trial.

This case tragically demonstrated the futility of conventional sentencing practices in dealing with pathologically dangerous persons. From the beginning there was little doubt in anyone's mind that Ohlsen was psychopathically dangerous. He could have been detained in a mental hospital until he was considered to be no longer dangerous; he could not be detained in prison beyond the expiration of his sentence.

### Legislation

In shocked reaction to these crimes, the Massachusetts legislature promptly enacted a new law designed to prevent such tragedies. Attempts to implement this new law failed, and several dangerous sex offenders were set loose. The present law, enacted in 1958, provides for indefinite detention and treatment of dangerous sex offenders.<sup>23</sup> It created a new quasi-medical entity, "sexually dangerous

22. Mass. Gen. Laws Ann. ch. 123, § 1 (1955); Harry L. Kozol, "The Psychopath before the Law," *New England Journal of Medicine*, March 1959, pp. 637-44.

23. *Supra* note 21.



person," and gave psychiatry the responsibility for the diagnosis and treatment of such persons. Thus the law tacitly took notice of the menace to public safety posed by certain persons "whose misconduct in sexual matters indicates a general lack of powers to control . . . sexual impulses . . . and who as a result [are] likely to attack or otherwise inflict injury on the objects of [their] uncontrolled or uncontrollable desires."<sup>24</sup>

In 1959 the Center for the Care and Treatment of Dangerous Persons was established to provide for the administrative and clinical implementation of this law. Criminal conviction is a prerequisite to application of the law. Generally the conviction is for a sex crime, but sentence to any detention facility for *any* type of crime subjects the offender to the scrutiny and authority of this law. A history of past sex offenses may very well bring the person under diagnostic observation.

Persons convicted of a sex offense may be referred to the Center for diagnostic study either before or after sentencing. The law provides indeterminate commitment for those who are diagnosed as "sexually dangerous" and so adjudicated in a civil hearing; it requires "treatment" for each patient regardless of his psychiatric status, personality structure, or intellectual resources; and it provides for release on parole and judicial review and intervention. It is "unique in the history of criminology because it specifically delegates primary authority and responsibility to psychiatry rather than to penology. Only time will tell whether or not psychiatry will do any better or for that matter any worse than penology."<sup>25</sup>

24. Mass. Gen. Laws Ann. ch. 123A, § 1 (1958).

25. Harry L. Kozol, "The Medico-Legal Problem of Sexually Dangerous Persons,"

The magnitude of the burden assumed by the Center in attempting to implement this new law is not difficult to appreciate. We had neither precepts nor precedents to guide us. The literature of psychiatry was virtually silent on the subject.

### Case Material

Our case material consists of 592 male convicted offenders who were remanded to our facility for diagnostic study. Psychiatrists assigned by the Massachusetts Department of Mental Health selected them after screening more than two thousand inmates. Most had been convicted of sex offenses. None of the convictions was for patently nondangerous offenses such as voyeurism, exhibitionism, or fetishism, although such behavior had been a complicating factor in some cases. In several cases the offenses had been compounded by extreme violence: eight by murder, two by manslaughter, five by assault with intent to murder, and twenty-eight by assault with a dangerous weapon. Common to more than half of the 592 cases was the use of force, violence, or threats. Sixty-seven per cent (395 of the 592 offenders) were transferred from correctional institutions where they were already serving sentences. Because of legal technicalities, thirty-one of these persons were returned to prison to serve extremely long sentences. The remaining 197 (33 per cent) were referred to the Center directly after conviction but before being sentenced.

On the basis of our initial diagnostic studies, we concluded that 304 of these persons were *not* dangerous. Most of them were given prison sentences or were returned to the correction-

*Acta Medecinae Legalis et Socialis*, April-June 1963, p. 126.

al institutions where they had begun to serve their sentences. Eventually all were released.

We made a diagnosis of *dangerous* on 257 patients; on thirty-one of them the courts failed to concur and these individuals were ultimately released back into the community. The courts concurred in our diagnosis of dangerous in 226 cases and committed these offenders to the Center for a period of day-to-life. After varying periods of treatment, one hundred patients were released, eighty-two on our recommendation and eighteen against our advice. In all, forty-nine patients were released by the courts against our advice: thirty-one by rejection of our diagnoses at the time of initial study, and eighteen after a period of treatment.

Our patients' most recent convictions included 524 sexual offenses and 78 nonsexual offenses.

The discrepancy between the total number of patients referred for diagnostic study (592) and the total number of sexual offenses (524) is explained by the following considerations: Some of the prosecuting authorities dismissed the charges for sex offenses when the gravity of the associated crimes suggested the virtual certainty of long imprisonment, which would presumably satisfy the

ends of justice. In nine such cases the crimes ranged from kidnapping to murder. We also studied fifty-nine patients most of whom had prior convictions for sex offenses but all of whose most recent convictions were for nonsexual offenses. Several patients who were charged with a sex offense and another offense were the subjects of deals between their counsel and the prosecutors, in which the sex charges were dropped in consideration of a plea of guilty to the other charges. This did not prevent their later reference to the Center for diagnostic study.

Our patients chose mostly young victims. This is typical in sex crime, but the proportion may raise some questions about the validity and generality of our hypothesis that the essential elements of dangerous behavior are identical for all crimes. On the other hand, our sample of criminality may serve to confirm our hypothesis: the person who would assault a relatively helpless victim—a child generally invites feelings of protectiveness—must have an extremely strong urge to do violence.

#### The Dangerous Person

Diagnosis is our most difficult problem. What is a dangerous person? No such entity exists in the nosology of

TABLE 1  
MAJOR OFFENSES COMMITTED BY PATIENTS

Sexual Offenses		Nonsexual Offenses	
Indecent assault and battery	163	Assault with dangerous weapon	23
Rape	86	Assault and battery	15
Attempted rape	74	Kidnapping	10
Carnal abuse	49	Murder	8
Open and gross lewdness	39	Assault with intent to kill	5
Sodomy	29	Robbery	3
Incest	28	Breaking and entering	4
Other unnatural acts	62	Manslaughter	2
		Burglary	1
Total	524	Total	78



psychiatry. Accordingly, it devolved upon us to create and develop our own criteria and methods for implementing them. We examined the language of the Massachusetts statute and the probable intent of the legislature in the light of the tragic case which had led to enactment of the law.

We hypothesize that those elements of the personality that are responsible for violent sexual assaults are common to all violent assaultive behavior. The generality of our criteria and the validity of our hypothesis should be tested by application to a group of persons who have been convicted of nonsexual violent crimes such as murder, assault with intent to kill, mayhem, robbery by force, etc. Our criteria should be further controlled by application to a matched group of persons who have no history of dangerous behavior.

We conceive the *dangerous* person as one who has actually inflicted or attempted to inflict serious physical injury on another person; harbors anger, hostility, and resentment; enjoys witnessing or inflicting suffering; lacks altruistic and compassionate concern for others; sees himself as a victim rather than as an aggressor; resents or rejects authority; is primarily concerned with his own satisfaction and with the relief of his own discomfort; is intolerant of frustration or delay of satisfaction; lacks control of his own impulses; has immature attitudes toward social responsibility; lacks insight into his own psychological structure; and distorts his perception of reality in accordance with his own wishes and needs.

The essence of dangerousness appears to be a paucity of feeling-concern for others. The offender is generally unaware that his behavior inflicts suffering on others. The po-

tential for injuring another is compounded when this lack of concern is coupled with anger. These elements, anger and a paucity of feeling-concern for others, may be of remote or recent origin, they may be global or selective, and, in many patients, they can be traced back several years. Deeply ingrained or nurtured by circumstance, these components seem to facilitate the situation that leads to the final assaultive acting out—an unconscious self-fulfilling prophecy. When the patient commits the assaultive act, he appears as a social isolate who has remained at or regressed to an infantile level of emotional prematurity where his primary concern is to satisfy primitive needs immediately.

No one is totally primitive—concerned only with the immediate satisfaction of limited goals—or totally mature—maintaining judicious control of all impulses. The dangerous potential may be fixed and habitual, episodic, or sporadic. People cannot be divided into the dangerous and the nondangerous—the bad guys and the good guys. The spectrum is wide, with the extremely dangerous at one end and the absolutely nondangerous at the other. The ability to measure dangerousness and the factors that contribute to it is limited by our clinical judgment and experience.

#### PSYCHOPATHS AND DANGEROUS PERSONS

Our concept of the dangerous person is nearly identical with the classical stereotype of the criminal or antisocial psychopath. These terms are synonymous with sociopath, character disorder, or antisocial personality.<sup>26</sup> Stürup has noted that it is "unneces-

26. American Psychiatric Association, "Diagnostic and Statistical Manual of Mental Disorders," 2nd ed., 1968, p. 43.

sary to discuss the meaning of terms such as 'psychopath,' 'sociopath,' or whatever else our criminals may have been called, as they form a hard core fitting within all the accepted definitions of these terms."<sup>27</sup>

What is a psychopath? He is at one and the same time an abstraction, a generalization, and a specification. He is a member of a large class of unique individuals. He is not normal but he is not psychotic and he is not neurotic. And yet the diagnosis is not merely negative. It is based on various traits that distinguish him from the wide range of average personalities but do not spell out a predominantly psychotic or psychoneurotic state. Keep in mind that the term *psychopath* is an abbreviation for the more accurate designation of *psychopathic personality* (the latter being preferable because of its emphasis on behavioral fixity or habituality). Although there are vast differences among individual psychopaths, there are even greater differences between them and the average (normal) members of the community.

The state of being a psychopath is neither static nor exclusive. The status may be either fixed and habitual or episodic and sporadic, alternating with states of seemingly normal and mature control of impulses. Psychopaths, like other persons, may experience any type, degree, or mixture of other psychological phenomena. Most of our patients would probably fall into the general classification of *psychopath*.

Not all psychopaths are criminal, antisocial, or dangerous. A psychopath may be *asocial* without being *antisocial*. The *antisocial* psychopath is

aggressively hostile toward the established mores of the community and often works out his hostility by taking what he wants when he wants it, without regard for his victim. The *asocial* psychopath manifests his lack of interest in or hostility toward the established mores of the community by passive withdrawal from socially conformative activity or by exclusive pursuit of his own interests. We have noted elsewhere that psychopaths are generally considered the bane of society, but many, through their monumental artistic and literary creations, have proven to be a blessing to society.<sup>28</sup>

Society has often overlooked unconventional behavior in *asocial* psychopaths who have made notable contributions, but it has been diligent, and with good reason, in its attempt to protect itself from *antisocial* psychopaths. It cannot afford to be complacent about them—some are genuine threats. There appear to be many antisocial individuals dedicated to making trouble for themselves and others—warring on their fellow man individually and internationally. Therefore, a principal reason for facing up to the problem of the *antisocial* psychopath is self-preservation. Can anyone question how close psychopaths have come to the conquest and destruction of the present social order? The psychopath of tomorrow will be no different from the psychopath of yesterday: he will either enrich and create civilizations or he will impoverish and destroy them. What he may do to society depends on what society does about him.

The psychopath is also an incalculable expense. He represents a dreadful waste of human potential, and his ranks may well be growing. At times,

27. Georg K. Stürup, *Treating the "Untreatable"* (Baltimore: Johns Hopkins Press, 1968), p. 7.

28. Kozol, *supra* note 22.



society appears more concerned with protecting its physical resources than with conserving its human resources.

The antisocial psychopath is the joint responsibility of psychiatry and the law. Society treats the offending psychopath with a variety of devices, most of which are futile in preventing repetitions of antisocial behavior. Its attempts have been little more than a holding action, if even that. The conversion of such persons from social liabilities to assets is visionary, but it is difficult to question the value of the objective. The complacent and tacit defeatism which holds that most psychopaths are essentially unmodifiable is erroneous in principle and probably in fact. In numerous cases criminal psychopaths have exhibited extraordinary talents and capacities along conventional and socially acceptable lines. It is clearly in the interest of society to make a more intensive and sustained effort to recognize and rehabilitate the psychopath in the hope of preventing antisocial behavior and channeling his energies into socially contributive pursuits.

Increasing evidence suggests that the psychopath is made, not born, and that his attitudes and distortions are the result of conditioning relationships. It follows that he should be modifiable, and in some cases we have demonstrated that he is.

Robert Coles asks:

For every quiet, apparently harmless individual who becomes a criminal are there not dozens of manifestly angry and even crazy people who not only commit no crimes, but live extremely useful lives? Do not many so-called "ordinary" people share whatever pattern we find in a gifted person's personality? These are riddles, not ones to shame any professions, but not ones to go unacknowledged, or be buried in a display of wordy and dogmatic psychiatric interpretations.<sup>29</sup>

The term *psychopath* originally referred to a personality disorder described as moral insanity. The individual who suffered from the disorder was described as a moral imbecile. The terms *moral insanity* and *moral imbecile* have gone out of fashion, but what they convey has persisted—if only in the prejudices of many psychiatrists. Most psychopaths who come to the attention of psychiatrists have come in conflict with the accepted mores or morals of the community and have been stigmatized in terms that are hardly more charitable than the ones Prichard used in 1835 when he wrote:

There is a form of mental derangement in which the intellectual functions appear to have sustained little or no injury, while the disorder is manifested principally or alone in the state of feelings, temper, or habit. In cases of this nature the moral or active principles of the mind are strongly perverted or depraved, the power of self-government is lost or greatly impaired and the individual is found to be incapable, not of talking and reasoning upon any subject proposed to him, but of conducting himself with decency and propriety in the business of life.<sup>30</sup>

Psychopathy must be assessed in regard to quality, pattern, and quantity. There has been a tendency among psychiatrists to limit the concept of psychopathy to nonpsychotic, non-neurotic, antisocial behavior patterns. We have previously challenged this arbitrary limitation,<sup>31</sup> which often ignores the link between psychopathy and genius. The polar ex-

29. Robert Coles, "American Amok," *The New Republic*, August 1960, p. 14.

30. James C. Prichard, *A Treatise on Insanity* (London: Sherwood, 1835), p. 4.

31. Harry L. Kozol, "The Dynamics of Psychopathy," *Archives of Criminal Psychodynamics*, special psychopathy issue, 1961, pp. 526-41.

extremes of the psychopath are the takers and the givers, the *malefactors* and the *benefactors*. The former are the antisocial predators; the latter are the contributors and creators. Both are nonconformists. It is in the latter group that the geniuses appear. The difference between antisocial psychopaths and geniuses is in their goals rather than in their substance. Genius always involves originality, and originality by definition excludes imitateness—the essence of conformity. Not all nonconformists are psychopaths, whether they be simple social offenders or admired geniuses, but it is undoubtedly true that all psychopaths are nonconformists.

One may test the proposition that there is a qualitative difference between the antisocial psychopath and the genius with a hypothetical case that reflects common experience. In one culture certain works of art may be considered the product of a depraved personality, and therefore condemned. The creator may be characterized as a psychopath, but a decade later this same individual may be acclaimed as an original creator, a man of genius. This illustrates the unsoundness of excluding socially contributive abnormality from the category of psychopaths. If described purely in terms of egocentric interest in a circumscribed area and general obliviousness to conventional responsibilities, Modigliani, Eugene O'Neill, Baudelaire, and many others would undoubtedly fit into the category of psychopaths. They fit the same pattern as those who follow stereotyped, socially undesirable forms of activity.

The genius exhibits a fixity of interest and gives exclusive attention to his work, often without regard to anticipated rewards or consequences. Very few great contributors to litera-

ture and art have received adequate recognition or recompense of any sort in their own lifetime. Men who enrich us through the products of their originality are called geniuses, and they are praised for their persistence in working toward their goals. When the results of persistence are socially offensive, the perpetrators are often described as psychopaths. Society judges according to the nature and quality of the act rather than the actor.

If we distinguish between psychopaths in general and those who create works of genius, we notice that the productions of the genius seem to represent a higher and more refined type of activity than the more primitive gratificational activities of the psychopath. Therefore, the distinction might be related to the level of satisfaction sought by the individual. The lashing out at society that is represented in the artistic works of Hogarth, Goya, and Daumier and the seething criticism poured forth by Joyce, Cervantes, and countless others appear to be a higher level of social assault than does the behavior of the man who beats up an innocent pedestrian "for kicks."

The term *psychopath* need no longer be equated with terms of opprobrium and condemnation. A man may be fortunate to be a psychopath. Is society universally cursed by psychopaths in its midst or is it not occasionally blessed by the presence of some? Most of the interest, writing, and clinical work on this subject has been based on experience with socially undesirable personalities—such experience being in clinics, courts, and correctional institutions. This restriction is probably responsible for the erroneous view that all psychopathy is antisocial and qualitatively distinct from social contributiveness.



### Diagnosing Dangerousness

#### IRRELEVANCE OF STANDARD PSYCHIATRIC DIAGNOSIS

The terms used in standard psychiatric diagnosis are almost totally irrelevant to the determination of dangerousness. Less than 7 per cent of our patients are or have been psychotic according to the accepted use of the term. These patients are either chronically schizophrenic or have a history of flamboyant manifestations of such a mental disorder. The incidence of dangerous behavior among the vast numbers of persons who fall into the wide category of so-called schizophrenic mental disease is slight, but the presence of severe psychosis in a *dangerous person* immeasurably compounds the risk that he will do terrible harm. Marked neurotic manifestations, including anxiety states and obsessive-compulsive states, occur in 15 to 20 per cent of our patients. Depressions of varying severity occur in about 24 per cent of our patients, but manic-depressive psychosis appears to play a part in no more than 2 or 3 per cent. None of these conditions is mutually exclusive.

#### DIAGNOSTIC CONSIDERATIONS

Dangerousness seems to be a result of multiple forces. It cannot be attributed to a single factor, and it is not detectable through routine psychiatric examination. There is no single test for it. We doubt that any tests or methods of examination, in and of themselves, are subtle enough to evaluate the delicate balance between those impulsive elements that lead to dangerous behavior and those self-controlling elements that inhibit it.

The diagnosis of dangerousness is based on inquiry and examinations that extensively pursue areas of con-

cern not fully dealt with in routine psychiatric assessment. There are no rigid criteria of dangerousness; there are only clues gleaned from a meticulous inquiry into multiple aspects of the personality. We have developed these clues out of painstaking years of trial and error, in the course of which we have developed frames of reference for investigation of the personality. Out of these investigations emerges our clinical *prediction* as to the patient's future behavior.

Our frames of reference are not fixed nor are they proposed as a rigid schema for examination; rather, they are a guide for the clinician who is charged with the responsibility of advising the court as to a person's potential. Diagnosis in each case is a clinical judgment of the collated data. The diagnosis of dangerousness is made when the *total* study clearly places the patient within our concept of the dangerous person as epitomized above.

#### DIAGNOSTIC METHODS

Each diagnostic study is based on clinical examinations, psychological tests, and a meticulous reconstruction of the life history elicited from multiple sources—the patient himself; his family, friends, neighbors, teachers, and employers; and court, correctional, and mental hospital records.

The clinical examinations are made independently by at least two psychiatrists, two psychologists, a social worker, and others. The interviews are designed to encourage free communication by the patient. They are neither confrontational nor inquisitorial but unstructured and informal. The problem for the examiners is to elicit information relevant to our areas of concern, and this can best be done by informality and as-



tute indirection. The consistency of our diagnoses depends, at least in part, on the fact that the director and several members of the senior and consulting staff have been involved in this program from its inception.

Of paramount importance is a meticulous description of the actual assault. The potential for violent assaultiveness is the core of our diagnostic problem, and the description of the aggressor in action is often the most valuable single source of information. The patient's version is compared with the victim's version. In many cases we interview the victims ourselves. Our most serious errors in diagnosis have been made when we ignored the details in the description of the assault. How was the victim chosen? Was the choice specific and meaningful or was it random and incidental? What was the victim in the aggressor's eyes?

The difficulty involved in predicting dangerousness is immeasurably increased when the subject has never actually performed an assaultive act. This is particularly relevant to involuntary mental hospitalization and to proposals for preventive detention. We submit that to properly assess indications of *possible* dangerousness in the absence of an actual instance of dangerous acting out requires the highest degree of psychiatric expertise and may well exceed the present limits of our knowledge. Who knows how many persons have the same traits as our patients but have never acted out dangerously and never will? No one can predict dangerous behavior in an individual with no history of dangerous acting out.

Halleck's observation epitomizes the problem:

The psychiatrist has few more important functions in criminology than evalu-

ating the probability that a given offender is likely to do violence to his fellow man. It must be reluctantly admitted that there is little science to be brought to this most sensitive task. Research in the area of dangerous behavior (other than generalizations from case material) is practically nonexistent. . . . Predictive studies which have examined the probability of recidivism have not focused on the issue of dangerousness.<sup>32</sup>

Halleck further supports our general position when he asserts that "no single factor is a necessary or sufficient cause of dangerous behavior. Prediction of dangerousness must ultimately be based upon an overall subjective impression which is based upon an understanding of the interrelatedness of many factors."<sup>33</sup>

#### DIAGNOSTIC FRAMES OF REFERENCE

In each study we explore the regions of the personality that we consider relevant. Since multiple forces and experiences influence the personality, we seek information on themes and experiences in the patient's history. We have developed wide frames of reference and lines of inquiry designed to reveal and give in-depth dimension to the structure and dynamic potential of the personality we are studying. In practice, we pose a series of questions to *ourselves*. These reflect some but not all of our frames of reference and lines of inquiry. They do not constitute a check list, and they are not complete or final. They are suggestions and reminders to *us*—not a questionnaire put to the patient. A series of these questions follows:

32. S. L. Halleck, *Psychiatry and the Dilemmas of Crime* (New York: Harper & Row, 1967), p. 314.

33. *Ibid.*

With respect to the use of force and violence:

Was he aggressively and wantonly cruel? Did he enjoy inflicting pain? What was his affect or emotional state at the time he perpetrated his crime? Did he have any identification with his victim?

Was he angry? With his victim? With whom—or at what? Since when? Was he mad at the world or specifically angry with a person or a class? Was the anger realistic and justified or unrealistic and disproportionate? What was the fate of this anger? Did it persist or evaporate?

Is he cruel toward himself? Does he enjoy suffering? How has he reacted to frustration or delay of satisfaction? With violence? With anger? With both? Must he have immediate satisfaction? Has there been any expression of violence in his drawings, writings, statements, fantasies, dreams?

What is the subject's view of himself?

How does he feel about what he sees in himself?

What is his conception of an ideal person? Whom does he admire? Whom is he for? Who are his heroes? Whose exploits does he applaud? Whom does he tend to imitate in speech and manner?

Whom is he against?

What is the subject's view of others?

Are they his potential enemies and he their potential victim? Are they his potential prey?

Are they nonexistent as persons and seen only as objects that he may use or exploit? Does he confuse their identity?

How does he relate to others?

Is he a social isolate, either alienated from other persons or never affiliated with them?

Does he have sympathetic identification with others?

What is his view of his prospects for the future?

Is he optimistic or pessimistic? Is he hopeful or discouraged? Is he depressed?

Does life hold any meaning for him? What?

What was his view of himself vis-à-vis the general community?

How has he related to other persons? How has he dealt with authority figures?

Did he have difficulty in school and work adjustments?

How did he get along with his peers? Did he feel that he belonged? Or was he a loner? Did he feel dependent on his peers? Did he crave their recognition and respect?

Was he concerned about his status in the eyes of others?

Was he embittered? Did he feel frustrated, rejected, discriminated against, deprived, unrecognized, mistreated, abused, in short—victimized? Did he feel threatened and persecuted? Did he have a sense of longing and anger with a concomitant sense of despair about ever dissipating this hunger?

How did he relate to his family?

Was the family constellation meaningful? In what way?

Was there conflict with parents? With siblings?

Did the patient feel loved, supported, encouraged by either or both parents? Did he feel threatened, disdained, rejected?

We are interested in the patient's general life-style. Was he conventional and socially conformative and responsible, or was he unconventional, irresponsible, and opposed to social standards? We are interested in the nature and amount of control that he asserted in his life-pattern of behavior. Has control been by repression or sublimation? What has been the result?

There is nothing unique about the content of these diagnostic areas of inquiry. They are familiar to all students of human nature. Our selectivi-



ty and emphasis, arrived at by arduous trial and error, are what determine the consistency and uniformity of our diagnostic procedure.

#### ROLE OF PSYCHOLOGICAL TESTS

Psychological testing supplements our total diagnostic procedure. To our knowledge, there is no single test or combination of tests that can predict dangerous acting out. None of our testing is routine. It is specifically designed for each case according to the particular history and clinical findings. We rely principally on the Rorschach, the Wechsler Adult Intelligence Scale, the Thematic Apperception, the Draw-A-Person, and the Bender-Gestalt, supplemented occasionally by the Minnesota Multiphasic, Holtzman Ink Blots, Wechsler Memory, and others. These tests help define the following aspects of the patient's ego status: perception of human relationships; ability to cope with tensions that develop out of conflicts between indulgence and inhibition of instinctive drives; presence and strengths of adaptive controls; competence of the ego to adapt and synthesize ideas, emotions, and percepts; modes of dealing with anxiety and other emotions; and the relation of his general level of measured intelligence to his capacity to view a situation in its true proportions.

#### Treatment

##### RATIONALE AND METHODS

Treatment of all committed persons is mandatory. The object of treatment is to modify the patient's dangerous potential to insure that he will not be a danger to the community. If the staff considers the treatment

effective, the patient becomes eligible for release.

Individualization is the essence of treatment. Immediately after commitment a therapeutic plan is formulated for each patient, and this plan is regularly reviewed and modified. Individualization does not necessarily mean individual therapy, which is not necessarily the best treatment or a guarantee of success and early release. Individual treatment not only failed to modify some patients' potential but succeeded in contributing to their growing interest in themselves. In our opinion a combination of individual and group psychotherapy offers the greatest promise for the largest number. Each group therapist is responsible for each patient in his group and sees each patient individually at varying intervals. This has multiple value: it assures the patient that there is a specific continuing interest in him, it gives him an opportunity to say things that he might be reluctant to say in the group, and it allows the therapist to focus all his attention on the individual patient. In our opinion group therapy without individualization is specious. It is the individual who is held accountable by criminal conviction, not the group, and it is the individual, not the group, who will be considered for release.

Our treatment is based on contemporary psychiatry and psychology. We have no dogmatic bias and no therapeutic ax to grind. Out of necessity and ignorance, our approach is experimental. We have no firm answers and we doubt that others have, but we do have some emerging hypotheses which we are constantly testing. The ultimate test of these hypotheses will come when our patients are returned to the community.

In group and individual psycho-

therapy, we distinguish between intensive and supportive treatment. We try not to lecture to our patients and prefer that they make discoveries for themselves. However, we cannot simply try to outwait them. Some patients would long outlive us without uttering a meaningful word.

For the small group of patients who suffer from developmental retardation or psychologic regression and therefore cannot be helped by conventional therapy, we seek to effect benefit through repetitive social conditioning. Treatment for them is didactic and prescriptive.

Group therapy is an integral part of our program, but the emphasis on individualization is never abated. Originally treatment groups were established quite informally and haphazardly, based on selection by the therapists. Individual therapy was arranged in cases where early modification of the patient's dangerous potential seemed likely and also where such a modification seemed most unlikely. We tended to give most attention to the two extreme prognoses.

Only a limited number of our patients appeared to be likely prospects for conventional psychotherapy. This led us to consider experimental programs of treatment. In group therapy certain individuals appeared to progress more rapidly than others, and some seemed to have a disruptive or delaying effect on others. Accordingly, we established some groups on the basis of assumed treatability. A scale of treatment optimism was set up, and all therapists graded their patients on this scale. By analysis and consensus, one group was set up that consisted of the patients considered most treatable. Just what did we have in mind by this categorization? In retrospect, it is obvious that these pa-

tients verbalized well, appeared to empathize and identify with others and to be motivated (at least superficially) toward effecting changes in themselves, and were the most communicative and ideational. On the whole they appeared to make more rapid progress than other types of patients. However, we discovered that, in some cases, we had been overimpressed by their apparent development of insight—manipulated by our own preconceptions of therapeutic progress. Conversely, some of the patients in our least treatable group surprised us by their apparent progress.

We set up two intensive treatment groups on the basis of a sociometric study. Each patient named three others with whom he would most like to be in group therapy and three with whom he would least like to be in therapy. We selected two core individuals for each group; according to their preferences and aversions, two groups of ten emerged. One consisted of patients who were markedly neurotic; the other consisted of psychopaths. The contrast between the two groups was striking. The psychopaths tended to select one another. Some attempted to enhance their exclusive interest in themselves by monopolizing conversations and assuming a pseudotherapeutic stance that revealed their belief that the *others* needed changing, not themselves. At the end of the treatment year the group formed on the basis of a neurotic core individual, who himself had shown an excellent treatment potential, appeared to have made considerable progress, and some of its members were recommended for early parole. On the other hand, the group made up of psychopaths made substantially less progress. No group cohesion developed, and there was little



change in the manner of social interaction.

We are particularly interested in the treatment of psychopaths. This term is generally equated with hopelessness and pessimism. Our experience suggests that total condemnation of psychopaths is not properly founded and that some, at least, are susceptible to substantial modification of their dangerous potential.

In another experiment homogeneous groups were established according to the patients' crimes. In these groups the content of disclosure and discussion was clearly different from that revealed in earlier groups. Patients who were relatively uncommunicative in earlier groups spoke more freely and frankly. Having an offense in common seems to be more significant for psychotherapeutic purposes than having a personality disorder in common, whether it is neurotic, psychopathic, or psychotic.

Neither drugs and hormones nor any other chemical or physical modalities play any part in our basic program of treatment. Dangerousness is too subtle to be materially modified or affected by any specious modalities of treatment. Neuroanatomical and neurophysiological research has not progressed to the point where simple extirpation of brain centers or pharmacological intervention can be generally applied. There may be rare exceptions to the latter when epileptic-like phenomena are demonstrated in association with explosive outbursts of violence. Such exceptions, even when demonstrated, only prove the generality of our position.

#### VOLUME AND INTENSITY

As of September 1, 1971, 149 patients were assigned to treatment. Ninety-seven patients (65 per cent) were assigned to group psychothera-

py: thirty-four to two-hour per week groups and sixty-three to one-hour per week groups. Of 127 patients (85 per cent) assigned to individual psychotherapy, 113 were given intensive treatment (ninety-one for one hour per week and twenty-two for two hours per week) and fourteen were given supportive treatment two hours per month.

Of the 149 patients, sixty-seven were assigned to both group and individual treatment, twenty-two received only group treatment, and sixty received only individual treatment. Ninety per cent (135 patients) were assigned to at least one hour of psychotherapy per week and 50 per cent (seventy-five patients) to at least two hours per week.

There were thirteen treatment groups (five two-hour per week groups and eight one-hour per week groups). These groups varied in size: one had twelve patients, one had eleven, one had ten, three had nine, one had seven, three had six, and three had four. The mean number of patients per group was 7.5.

There were twenty-two patients in our out-patient program. They were treated as follows: eleven, weekly; six, bimonthly; two, monthly; and three, not regularly.

#### The Safe Person

In assessing the personality, we seek information about the patient's assets—the *safe* elements in the personality—as well as his liabilities. No one is totally and exclusively safe or dangerous. *Safeness* is the complement of dangerousness. Its determination is at least as difficult as that of dangerousness. Releasing an offender from sentence or other commitment requires at least as much expertise as determining that an offender is dangerous. Release procedures endorse the



safeness of a person and should be carried out by a competent aggregate of experts.

We conceive of the *safe* person as one who has generally mature attitudes toward social responsibility, has developed a compassionate concern for the welfare and interests of others, has divested himself of hostilities and resentments, is relatively free of gross distortion of reality, has developed insight into his own nature, appears to have developed strong conditioning against repetition of his original offensive behavior, and specifically recognizes that freedom in the community involves responsibility as well as gratification.

How do we make the diagnosis of dangerousness? How do we use all this material? Our final diagnosis is based on an estimate of the relative quantity and intensity of dangerous elements contrasted with the safe ones. Our clinical judgment of the comparative weight of these elements determines the final diagnosis. We make the diagnosis when the total study clearly places the patient within our concept of the dangerous person.

#### Social Remonstrance and Violence

We do not equate dangerousness with contemporary patterns of social remonstrance and violence, although the latter may be perceived as dangerous by target establishments. We define dangerousness as a pathological self-serving potential for violence. An individual participant in mass violence may or may not be dangerous, depending on whether his motivation is essentially altruistic (based on a compassionate identification with others), or egoistic (concerned primarily with venting personal rage). Altruism and egoism reflect polar levels of maturity. The presence of anger in a participant is not pathog-

nomonic of a dangerous potential if it reflects a primary concern for others. Rage at oppression has been considered righteous from time immemorial. In the context of history, when the absence of alternatives has engendered desperation, extreme violence resulting in injury to property and persons has been socially acceptable. Primary insistence on violence when alternatives do exist and without benevolent regard for the consequences to others is another thing. As history has shown, leaders of great nations may be infinitely more dangerous than the most depraved lone killer. The dynamics are identical; only the scope and magnitude of their crimes are different.

#### Results of Treatment

##### RECIDIVISM

The validity of our diagnostic criteria and the effectiveness of treatment may be judged by comparing the behavior of patients released on our recommendation with the behavior of those who were released against our advice. A total of 592 patients were admitted to our facility for diagnostic observation; 435 were released. We recommended the release of 386 and opposed the release of forty-nine. The recidivism rate was substantially higher for the group of patients released against our advice.

Age is a significant variable in recidivism. Advanced age is often correlated with a decrease in criminal behavior. This is not relevant to our results because the mean ages of our patients fall within the prime area for criminal recidivism. The mean age for all 435 released patients was 35.61; for the 386 patients released on our recommendation, 35.26; and for the forty-nine patients released against our advice, 38.38. Table 2 shows

the recidivism rates of all 435 released patients, of the 386 patients *recommended* for release, and of the forty-nine patients *not recommended* for release.

Of our 386 recommendations for release, 304 were made at the time of the initial diagnostic study. Twenty-six of those initially recommended for release subsequently committed serious assaultive crimes, producing a recidivism rate of 8.6 per cent. After receiving treatment for an average period of forty-three months, eighty-two additional patients were recommended for release; of these, five subsequently committed serious assaultive crimes, producing a recidivism rate of 6.1 per cent. One of these five patients committed murder in the course of a burglary. A report of that case follows:

WB was committed to the Center at age sixteen following conviction for burglary and assault with intent to commit rape. His criminal history—convictions for assault and battery, possession of a weapon (knife) with intent to commit a felony, and assault with intent to rape—began when he was ten years old. During five years at the Center he was the subject of group and individual psychotherapy. He appeared to have made encouraging and

steady progress from year to year and to have matured considerably. His release was recommended and effected. Nine months after his release, he stabbed a young woman to death when she surprised him while he was burglarizing her apartment.

A review of WB's prerelease evaluation suggests that the staff did not give adequate attention to his antisocial history of violence. Immediately preceding the attempted burglary and murder, the patient had withdrawn from treatment (he was receiving out-patient care as a condition of his parole). A prompt and adequate follow-up on the reasons and motivation for this withdrawal was not made.

In summary, of the 386 patients recommended for release, a total of thirty-one subsequently committed serious assaultive crimes, producing a recidivism rate of 8 per cent. The mean age of this group of recidivists was 33.84.

A total of forty-nine patients were released against our recommendation. Of these patients, seventeen subsequently committed serious assaultive crimes, producing a recidivism rate of 34.7 per cent. Despite our diagnosis of dangerous, the court found thirty-one (63 per cent) of these for-

TABLE 2  
RECIDIVISM: COMPREHENSIVE STUDY OF ALL PATIENTS RELEASED

Recommended for Release	Number	Recidivists	
		Number	Per cent
At time of initial diagnostic study	304	26	8.6 %
After commitment and treatment	82	5	6.1 %
<b>Total</b>	<b>386</b>	<b>31</b>	<b>8.0 %</b>
<b>Not Recommended for Release</b>			
At time of initial diagnostic study	31	12	38.7 %
After commitment and treatment	18	5	27.8 %
<b>Total</b>	<b>49</b>	<b>17</b>	<b>34.7 %</b>
<b>Total of all patients released</b>	<b>435</b>	<b>48</b>	<b>11.0 %</b>



ty-nine patients to be nondangerous at the termination of the initial statutory sixty-day period of observation. Of these thirty-one, twelve subsequently committed serious assaultive crimes, producing a recidivism rate of 38.7 per cent. One of these twelve patients committed murder. A report of that case follows:

JM was thirty-five years old when he was admitted to the Center for diagnostic observation after having pleaded guilty to a charge of indecent assault on his nine-year-old daughter. Investigation indicated that when his daughter had resisted his sexual assaults he had brutally beaten her with a garrison belt, producing multiple abrasions and lacerations on her abdomen, back, thighs, and head. These sexual assaults had been taking place for two years. The child, fearing her father's threats, had not told her mother. Examination revealed lacerations and abrasions of the hymen. He had also beaten her for refusing to invite a little female playmate to join in his sexual acting out. There was a history of aggressive and cruel treatment of his former and present wives and episodic bouts with alcohol. He had made an adequate adjustment in the armed forces and in his work.

He was diagnosed as dangerous, but the court was reluctant to accept this finding and referred him back to the Center for further study. The second period of observation confirmed the original diagnosis of dangerous, and the court was warned in extremely strong language that the patient would repeat his assaults but this time with "dangerous force or violence." Despite this testimony the court voided the entire procedure, dismissed the petition for commitment as a dangerous person, and gave the patient a terminate sentence to prison. He was paroled and released from prison seven months later. Nine months after his release he stabbed a female friend to death.

The prediction that JM would seriously injure another person was ignored by two successive courts. The

patient wrote to us from prison that he regretted having contested our diagnosis of dangerous and wished he had availed himself of the opportunity for treatment in the Center.

Eighteen (37 per cent) of those released against our advice were released after treatment for an average period of thirty months despite our insistence that they were still dangerous. Of these, five subsequently committed serious assaultive crimes, producing a recidivism rate of 27.8 per cent. One of these five patients committed murder. A report of that case follows:

CP was a chronic psychotic who was committed to the Center at age twenty-four for having molested a child. During his five years of treatment, he was generally docile but suffered three acute psychotic episodes in which he experienced accusatory and threatening hallucinations of terrifying proportions. It appeared that treatment under the constant supervision of a regular mental hospital would be more humane and appropriate for CP than continued detention at the Center. Arrangements were effected for judicial release from the Center and transfer to the jurisdiction and supervision of a regular state hospital. These conditions were not implemented by the responsible authorities, and the patient was permitted to drift into the community without supervision or help. He suffered an acute exacerbation of his underlying psychosis and killed a five-year-old boy after sexually molesting him. He admitted his act to the police and was sent to the maximum security state hospital for the mentally ill criminal.

A psychotic person with a history of violent assaultiveness may harbor an extremely dangerous potential even if he is consistently docile in the institutional setting. The danger is compounded if, as in this case, such a person experiences a recurrence of acute psychosis with threatening hallucinations and depression. CP's be-

havior was the result of a lethal ambivalence: on the one hand, affectionate identification with the child and, on the other, a self-hating identification with the child as the psychotic surrogate for himself.

We are aware that 65 per cent of the forty-nine patients whose release we opposed have not committed serious assaultive crimes during nearly five years of freedom.

Of the 386 patients we recommended for release, 304 were found to be nondangerous at the time of initial diagnostic examination and were not detained at the Center. Most of them were given prison sentences and subsequently released into the community. Twenty-six recidivated. The remaining eighty-two were originally diagnosed as dangerous and committed to the Center for treatment. After treatment for an average period of forty-three months, these patients were diagnosed as no longer dangerous to others, and they were released by parole or court order. Of this latter group of patients, only 5 (6.1 per cent) subsequently committed serious assaultive crime.

#### Comment and Conclusion

These figures suggest that treatment was successful in modifying the dangerous potential of 94 per cent of the patients we recommended for discharge after treatment for an average period of forty-three months. Twenty-eight per cent of the patients released from treatment against our advice subsequently committed serious assaultive crimes; 72 per cent did not.

Our recidivism rates are not strictly comparable to those in general peno-

logical practice. Our figures are restricted to the potential for committing serious assaultive crimes. In conventional penological practice, recidivism rates include parole revocations (many for minor technical violations that would not, in and of themselves, be considered as crimes) and any convictions for offenses (including minor ones) that entail incarceration for thirty days or more. These recidivism rates may be relevant to the economics of re-arrests and judicial reprocessing, but they are not relevant to the dynamic causes and control of serious crime. There is a marked paucity of detailed data on recidivism in persons convicted of serious assaultive crimes. When we analyzed the recidivism in our treated patients according to conventional penological practice, we discovered that for the one hundred patients who were treated and subsequently released (eighty-two recommended for release, eighteen released against our advice), the general recidivism rate including all types of arrests and parole revocations (even for minor violations) was 32 per cent. This is less than half the national rate derived from data supplied by all fifty-one jurisdictions as reported in the *Uniform Crime Reports*.<sup>34</sup>

It appears that dangerousness can be reliably diagnosed and effectively treated. It is clear that we must improve our diagnostic and therapeutic competence to insure that fewer dangerous persons are let out and fewer nondangerous persons are kept in.

34. Federal Bureau of Investigation, *Uniform Crime Reports* (Washington, D.C.: U.S. Government Printing Office, 1970).



# PSYCHOTHERAPEUTIC CONFIDENTIALITY

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## PRIVILEGE

A privilege is the power to refuse, in the course of a law suit, to disclose certain evidence and to prevent another person from disclosing the same. There was no doctor-patient privilege at common law, but it exists in varying forms by virtue of statute in 43 states. / A "psychologist-client" privilege exists by statute in about 20 states and 4 states (3 of which have no doctor-patient privilege) have a psychiatrist-patient privilege by statute.

The basic purpose of the doctor-patient privilege is to enhance the quality of medical services by encouraging those seeking treatment to make frank, candid revelations regarding their conditions. In the absence of the privilege, the fear of disgrace or embarrassment through disclosure may inhibit the patient and cause him to conceal from his doctor information that would be helpful in diagnosis and treatment. The privilege is also intended to protect the individual therapeutic relationship by relieving it of the disruption that the therapist's testimony might cause.

Although the privilege is sometimes worded so as to protect only "confidential communications" made by the patient, the privilege, as a result of either more broadly worded statutes or by judicial construction, usually applies to non-verbal information more passively provided by the patient, through laboratory tests, X-rays, observation and the like. The New York statute, quite typically, protects "any information which [the physician] acquired in attending a patient ... and which was necessary to enable him to act in that capacity ...". In addition, as a logical extension, the privilege generally covers the physician's diagnoses, his statements to the patient in the course of treatment and the treatment itself. By further extension the privilege covers doctor and hospital records which contain the same type of information.

The privilege also generally applies to other physicians who are contacted by the patient's physician for consultations, to partners of the physician and other hospital staff doctors, and to persons assisting the physicians, such as nurses. In some states, however, third persons, such as nurses, are not covered even though they serve as agents of the physician; and the reported cases in which pharmacists have been involved do not extend the privilege to them. This creates the anomaly of making discovery of medication, but not other treatment, available.

Despite the breadth to which the doctor-patient privilege has been extended to make it effective in cases in which it is upheld, it has met considerable disfavor and skepticism. Pro-

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/ "Appendix, Report of the Secretary's Commission on Medical Malpractice" 178 (U.S. Department of Health, Education and Welfare 1973) (hereinafter, "Appendix, Report of the Secretary").

fessor Wigmore argued strongly that the privilege is not justified and courts have frequently felt pressed to circumvent it in order to admit significant evidence and to accomplish substantial justice and avoid fraud. The Advisory Committee of the Judicial Conference in its explanatory Note to Rule 504 of its proposed Rules of Evidence for the United States Courts and Magistrates listed the following exceptions, some judicial, some legislative:

"communications not made for purposes of diagnosis and treatment; commitment and restoration proceedings; issues as to wills or otherwise between parties claiming by succession from the patient; actions on insurance policies; required reports (venereal diseases, gunshot wounds, child abuse); communications in furtherance of crime or fraud; mental or physical condition put in issue by patient (personal injury cases); malpractice actions; ... some or all criminal prosecutions ... malpractice cases and disciplinary proceedings."

The general pattern has thus been to extend the coverage of the privilege over a broad range of persons and records to make it meaningful when it is being applied, but to carve numerous exceptions to achieve disclosure in furtherance of particular social interests or of justice in particular cases. The doctor-patient privilege has been dishonored by frequent creation of exceptions in large part because of beliefs that, for the great majority of injuries and diseases, the patient needs no promise of confidentiality to encourage full candor, and that the privilege is frequently invoked for dilatory purposes or to conceal information which would be neither embarrassing, counter-therapeutic nor destructive of the therapeutic relationship to disclose.

PSYCHOTHERAPIST-CLIENT PRIVILEGE

In contrast to the arguments against a consistently applied doctor-patient privilege, a strong, convincing case exists for a broad and reliable psychotherapist-client privilege. Judge Edgerton cast the distinction well: "Many physical ailments might be treated with some degree of effectiveness by a doctor whom the patient did not trust, but a psychiatrist must have his patient's confidence or he cannot help him." /

Examining the psychotherapist-client privilege in terms of basics, i.e., the 4 conditions which Professor Wigmore set forth as prerequisites to a justified privilege, it appears that such a privilege is justifiable. The conditions are:

- "(1) The communications must originate in a confidence that they will not be disclosed.
- (2) This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.
- (3) The relation must be one which in the opinion of the community ought to be sedulously fostered.
- (4) The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation."

The first two conditions are obviously fulfilled. It is generally acknowledged that patients with psychological problems usually must reveal the most private, painfully embarrassing and potentially humiliating facts about themselves and their thoughts in order to get help. It is true that, "the psychiatric patient confides more utterly than anyone else in the world." A fear of disclosure of such clearly confidential information would be detrimental to the psychotherapeutic relationship. Indeed, these patients often dread the disclosure of even the fact that they have been in therapy.

The third question -- whether the community believes the relation should be fostered -- seems well settled. Psychiatry, psychology and other mental health professions and occupations certainly have their detractors, as do all major professions, but there are very few people who would not favor the idea of strongly encouraging people in mental or emotional trouble to seek professional help. Moreover, society employs mental

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/ Taylor v. United States, 22 F. 2d 398, 407 (D.C. Cir. 1955).



health professionals widely to minister to the needs of the mentally disabled in a great variety of public institutions -- e.g., mental health centers and hospitals, military and veterans' hospitals, court and prison systems, public school systems and colleges. The expenditure of tax revenues for their services is more than adequate evidence that the community attaches considerable value to and fosters the relationship.

Likewise, in the fourth area of inquiry, balancing the comparative benefits and detriments to treatment with the benefits and detriments to litigation, the privilege is easily justified.

Testimony by the psychotherapist against the patient's wishes in individual cases would clearly be destructive of the psychotherapist-patient relationship. Moreover, unlike what one would expect in the area of physical ailments where the patient would simply be expected to change doctors, such a betrayal of confidence by a psychotherapist would be likely to have a strong negative effect on the patient's consideration of consulting, or even cooperating with, another psychotherapist. Thus, absence of the privilege would make it considerably less likely that some persons in need of treatment would ever gain the benefit of it. In the criminal area this means that compelling the therapist's testimony would, in some cases, foreclose what may be the best way of dealing with the objectionable or dangerous behavior.

The benefit of the psychotherapist's testimony to litigation is considerably less certain. Disclosure may be a significant benefit in particular cases and misleading in others. Since the grist of psychotherapy is fantasy, delusion, dream, feelings, and disoriented or disfunctional thought, communications made in that setting have an aura of unreliability and disutility for conventional fact finding purposes despite their value in therapy. Moreover, there may often be a temptation for the psychotherapist-witness to bend or conceal the truth in order to protect the patient, or personal or family relationships from harm which may actually be more important, on at least the psychotherapist's moral scale, than providing information for factfinders.

Not only does the psychotherapist-client privilege meet the classic legal test for a valid privilege, but it has justification in the social value of respect for individual privacy; and a good argument can be made that the constitutional right of privacy requires such a privilege. In 1971, in the case of Griswold v. Connecticut, 381 U.S. 479, the United States Supreme Court held unconstitutional the Connecticut prohibition against the use of contraceptives by married persons and the prescription of contraceptives for a married person. In that case and in a 1973 case, Roe v. Wade, 410 U.S. 113, in which the Court struck down the Texas abortion statute, the Court firmly established, without precisely delimiting, "a right of personal privacy or a guarantee of certain areas or zones of privacy ... under the constitution." Given the profound intimacy of the psychotherapist-client relationship, it would be difficult to consider it as lying outside the



constitutional zone of privacy. Mr. Justice Douglas, writing for the Court in the Griswold case, cited the possibility of a police search of the marital bedroom for evidence of the use of contraceptives and found "the very idea repulsive to the notions of privacy surrounding the marriage relationship." Similar sensitivities should find repugnant the notion of forcibly and publicly, against the client's desires, searching the psychotherapist-client relationship for evidence in litigation. Finally, it seems socially desirable for disturbed people to find sanctuaries, such as the psychotherapist's or clergyman's office, where in an effort to obtain help they may feel free to talk without fear of their words becoming public property. In this complex age, in which information about us is increasingly impersonally compiled and stored in data banks, and in which the stressful conditions of our competitive and technological environment are increasingly difficult to escape, public policy should strongly encourage people to seek help for their problems. As part of that encouragement and as an enhancement of the therapeutic relationship, the state should protect the privacy of the relationship.

Despite the fact that large numbers of states have doctor-patient and psychologist-client privileges, there is a striking need for reform. The scope of such privilege statutes is generally inadequate and the reliability (predictability) of the application of the privilege is highly uncertain. This is a most unsatisfactory situation because a vital feature of any effective privilege is the certainty that it will be upheld. If the client knows that the privilege is not reliable, it cannot serve to encourage him to be open and candid.

The privilege applied to the psychotherapist-client relationship is clearly justified and should not suffer from the same range of exceptions and uncertainties which have grown up around the doctor-patient privilege. It is important to note that the first doctor-patient privilege statute was enacted in 1826 in New York. In the intervening century and a half, many other states enacted the privilege in various forms and a vast body of experience of application and misapplication, interpretation and misinterpretation has been developed. This experience can be of great value in designing legislation to establish and define and delimit psychotherapeutic confidentiality so as to render it optimally reliable and useful.

Although psychologist-client privilege laws are of more recent vintage, most of them have no value as a guide to legislative design. About half simply word the psychologist-client privilege in terms of being on "the same basis" as the attorney-client privilege. This is clearly not a very useful technique. The others do not represent significant improvements over the doctor-patient privilege statutes.

One of the most important developments in the field has been the 1961 Connecticut psychiatrist-patient privilege statute, which was drafted by an inter-disciplinary panel of professionals from law and psychiatry. This law was enacted in substantially

maintenance, disclosure and retention of hospital records, and case law extending the privilege law to contexts other than litigation. These various sources do not constitute a systematic, easily discerned set of principles for controlling the flow of confidential information. A major failing is that the law does not clearly define the responsibilities of non-professionals, e.g., insurance companies, employers, who obtain confidential information.

Moreover, these various principles generally do not clearly address many of the aspects of modern mental health care and the system for its delivery which present difficult, sometimes subtle, issues. Group therapy, family therapy, multi-disciplinary care, and relationships between mental health care providers and social agencies pose more complex questions than do the traditional setting of a single therapist and a single client. The computerization of mental health records and the use of data banks in the provision of care and administration of programs and in research raise conflicting considerations of privacy on the one hand and efficiency and scientific progress on the other. Additional problem areas include billing for mental health services, insurance claims, peer and utilization reviews necessary for accreditation, insurance and federal funding programs, group insurance plans that involve employer access to confidential information, and state occupational, drivers' and firearms licensing processes.

Most problem areas can be dealt with in a comprehensive statute to which all persons--therapists, lawyers, administrators, insurers, employers and others to whom confidential information is disclosed, as well as the subject of the information--can look for common guidance. The following proposal is an attempt to provide such a legal framework. The fundamental principles on which it is founded are as follows:

1. The protection of information related to mental health care and treatment is necessary in order to encourage those who require professional help to participate in treatment and to be totally candid with their therapists.
2. Since mental health care is provided by, or under the supervision of, non-psychiatric physicians, psychologists, social workers and other state-licensed professionals, a confidentiality statute should provide protection to information developed in both psychiatric and non-psychiatric settings as long as the therapist is licensed or certified to provide mental health care or treatment.
3. When the care or treatment of an individual entails the participation of non-professional persons, either those under the supervision of the therapist (e.g., hospital or mental health center staff) or those cooperating with him

(e.g., family members, group therapy participants, school teachers), such persons should be bound to observe confidentiality.

4. All persons employed at a mental health facility should have access to treatment information to the extent their duties require it, and persons engaged in bona fide training programs at such facilities should have similar access.

5. The primary determinant of the flow of mental health information about an individual to others outside the treatment context should be the informed, voluntary consent of the individual himself and such consent can only be given if the individual knows what the information is.

6. Blanket consent provided in the context of applying for health care insurance or claiming health care benefits is neither truly informed nor truly voluntary because the costs of and needs for treatment or care available only through insurance are overwhelming. Accordingly the amount and nature of confidential information available to insurers and their handling and storage of such information should be regulated by law in the interests of achieving an accommodation between personal privacy and sound insurance practices.

7. Authorizations for the disclosure of confidential information should specify the specific persons or agencies to whom disclosure is to be made and the purpose to which the information is to be put. Further disclosures and other uses without the individual's specific authorization should be prohibited.

8. Registers, data banks, and other accumulations of individually identifiable mental health records represent dangerous masses of information that might be disclosed negligently and that persons with strong economic, personal, social or political motives will have sufficient incentive to invade even at the risk of heavy civil and criminal penalties.

9. Electronic data processing of mental health information is useful for treatment, research and administrative purposes; but when it is used to create data banks that include individually identifiable data to persons outside the facility where care and treatment are provided, an unacceptable risk of abuse of confidential information exists.

10. Confidentiality should be a protective shield for the individual, but not a sword to be used in asserting fraudulent claims. Thus, confidentiality may be pierced when necessary in litigation, but only after all other sources of information have been exhausted and a court has, in private, reviewed the evidence for relevance and other considerations regarding admissibility and need for the confidential information.



the same form in Illinois / and Florida. Other valuable efforts to tailor a modern privilege law to the needs of the psychotherapeutic relationship have included those of the California Law Review Commission, whose recommended statute, as adopted by the California legislature in 196\_, expanded the privilege by adding to psychiatry other state-licensed professions involved in psychotherapy; the Advisory Committee of the Judicial Conference of the United States, whose proposed rules of evidence for the federal judiciary / included a "Psychotherapist-Patient Privilege" that would have covered communications between patients and medical doctors, "when engaged in the diagnosis and treatment of mental or emotional condition," or licensed or certified psychologist; and the recommended statute set forth in the Harvard Journal on Legislation, "A State Statute to Provide a Psychotherapist-Patient Privilege," 196\_ Harv. J. Leg. 307.

The statute herein recommended incorporates the protective features which are found to varying degrees in the foregoing laws and proposals so that confidential communications are given maximum protection. The recommended statute goes beyond the privilege laws, however, in order to protect confidentiality outside the litigation context.

#### Confidentiality

In 1969 Connecticut expanded its psychiatrist-patient privilege into a law giving protection to confidential information beyond the courtroom. In doing so, Connecticut recognized that harmful divulgence occurs in a wide range of settings and that a privilege law covers only a small part of the problem. Outside the courtroom, there are a variety of instances in which inquiries and investigations are made into the mental health history of individuals. Schools, colleges, insurance companies, investigative journalists, employers, landlords, social agencies, relatives, police, researchers, administrators and others all seek access to information and records regarding individuals' mental health condition and treatment. The legal controls regarding such disclosures reside in a patchwork of statutory, regulatory and case law. Relevant legal constraints are found in the constitutional right of privacy, licensing laws which impose a requirement of ethical conduct, including fundamental notions of privacy, implied conditions of confidentiality in the implied therapist-client contractual relationship, defamation laws, state laws, rules and regulations regarding the

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/ Illinois modified it by eliminating the patient-litigant exception in the divorce cases. See pages \_\_\_\_, infra.

/ The Committee-proposed rules of evidence were adopted by the Supreme Court, but congressional action prevented their going into effect. The proposed rules and amendments to them are presently being considered in the Congress.



## Electronic Data Processing and Data Banks

The use of computers to collect, store and produce data on mental patients has begun. In 1964 a computer was installed in the Hartford Institute of Living and in 1969 the Multi-State Information System (MSIS) for psychiatric patients began operating computers at Rockland State Hospital, Orangeburg, New York. In 1973 MSIS was receiving, through direct hook-up, automated data on psychiatric patients in five states and the District of Columbia. MSIS has helped to establish compatible computer systems in several other states. The State of Missouri, to cite another example, links its mental health facilities to a central computer facility. The plans apparently call for eventual installation of cathode-ray displays in "each doctor's office and nurses' station [in order to provide]...immediate access to all patient information." \*/

Such computer operations contain extensive, detailed information on mental health facility operations and on individual patients. Through sophisticated techniques they provide a variety of forms of information. Their usefulness is in three areas: the administration of a mental health facility (e.g., reordering drugs, tabulations of inpatient days of those over 65 for purposes of Medicare or Medicaid reimbursement, activity statistics to justify budget requests); program planning, evaluation and research (e.g., tabulations and cross-tabulations of services provided with comparisons to other facilities, data on services provided to specific geographic areas, age and sex groupings, etc.); and individual treatment (e.g., recording all data on medication and other therapy and providing automated summaries of histories, admission notes, etc.). In the areas of administration and program planning, evaluation and research, the computer can perform as brilliantly as the quality and detail of the information it is provided and the ingenuity of programmers and systems analysis allow. As in other systems, there is virtually no limit to the types of statistical compilations, cross-tabulations and summaries that the computers can be programmed to perform. As MSIS spokesmen point out, presently under its system,

"MSIS data are being used in support of many activities within the mental health delivery systems of the states. Accurate, timely statistics are

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\*/ Ulett, "Automation in a State Mental Health System," 25 Hospital and Community Psychiatry 77 (1974). Several other articles in the February 1974 issue of this publication describe the Missouri system. None, however, deal with privacy issues.

available on the numbers of patients served, the types of services rendered, the progress made, and the resources utilized. These data are scrutinized to compare programs and treatment modes, to analyze patterns of facility utilization, and to plan resource allocation.

"Data are also used in determining whether all segments of the population are served adequately and equally by a mental health facility. Statistics show who is being served by ethnic group, income group, age, sex, etc. and are used for planning extensions of existing programs, for developing new programs, and for correcting inequities.

"In the facilities, computer-kept data form the core of the patient record. Individual patient profiles detail progression through a treatment program. At the same time, data for the facility are aggregated and used for administrative and management purposes, e.g. to determine how much food or medication to order. Research studies are facilitated by the availability of large amounts of data and by the computer utility with which to perform the analysis.

"The system's capabilities are continuing to expand through the development of additional data collection and analysis techniques in such areas as patient billing, cost analysis, third-party payers, computer-suggested treatment modalities, automated utilization-review procedures, and program-evaluation methods."

With regard to individual diagnosis and treatment, it does not appear that the computerization is of much utility. It transforms routine reports which are entered on checklist forms into narrative reports, but these seem to be of little or no value over what the completed form would reveal. The computers can also respond with suggested diagnoses, but claims are not being made that a computer's diagnostic capabilities are of significant value to the psychotherapist. The main functions of the computer in individual cases are to track the progress and status of clients and to provide comprehensive data on their treatment and responses during therapy.

The challenge presented by electronic data processing of mental health records is that of achieving the maximum

benefits from computers consistent with protecting the privacy interests of individuals. Not all computerized operations in this field raise privacy concerns. Records of individual cases with client identifiers removed can be aggregated and used to evaluate the absolute and comparative effectiveness of treatment techniques and modalities and of particular facilities and practitioners. Indeed, careful analysis of aggregate data holds the promise of advancing the state of knowledge and understanding of how best to deal with common mental health problems. Also, electronic data processing can, it appears, enhance care and treatment in individual cases by providing swift analysis of relevant information and by accumulating data regarding diagnosis, observations, care and treatment and rapidly producing it in a convenient, useful format. As long as such electronic processing of individualized mental health data is accomplished by a self-contained computer operation on the premises of a mental health facility, it presents no issues of confidentiality greater than those involved in conventional, paper records. Even when off-site equipment is used, privacy concerns do not increase significantly if client-identifying information is removed prior to transmission. This can be accomplished through the use of coding mechanisms at the mental health facility in such a way as to insure that no one with either legitimate or improper access to transmission lines or the off-site equipment can determine the identity of particular clients. The matching of data to clients would take place at the mental health facility. \*/ Thus, just as in the case of a self-contained computer at the facility, client-identified data would exist only at the mental health facility.

Significant new confidentiality issues are raised, however, when electronic data processing involves the accumulation of client-identified data outside the facility where care and treatment are being provided. The first concern simply involves the proliferation of client-identifiable, confidential information to two previously non-existent sources -- the "outside" computer facility and the transmission lines between the mental health facility and the computer facility -- from which confidential information can be leaked. An even more serious concern arises when a

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\*/ Explaining such a process in simplistic terms, prior to transmitting data outside the facility, data processing personnel would substitute an artificial identifier for client-identifying data, e.g., a series of numbers would be substituted for name and all transmissions and retrievals of information regarding the client to and from "outside" equipment would be linked to the artificial or symbolic identifier. Data extracted from the computer would be matched, by data processing personnel at the mental health facility, with the client's name and passed along to treatment staff.

single computer facility receives client-identified information from a number of mental health facilities. Such a system produces a data bank of mental health information about individuals. Such data banks present extremely serious problems. First, they represent a reservoir of mental health information removed and apart from the mental health services provider and such sources of information are always more subject to misinterpretation or misuse than the original source. \*/ Records are imperfect witnesses. Despite their apparent objective nature, they are necessarily condensations and characterizations of events, conditions and the recorder's impressions and interpretations thereof. Since no two people use words by which such matters are recorded with identical precision, information obtained from non-original sources is inherently inaccurate to the extent that such sources attach unintended meaning or significance. To use a familiar analogy, someone who has obtained an employment performance evaluation report through a company personnel department may receive a very good, but unreliable, impression of that individual's skills and job performance. If the request for information were directed to the primary source, the reporting supervisor, one might learn that the supervisor had had little opportunity to observe the employee in question and, in fact, had some serious doubts about the employee's performance; but since the report had to be filed before a fixed deadline and the supervisor had not had time to confirm his misgivings before filing the report, he filed a very favorable evaluation rather than express possibly unfounded doubts about the employee. Similarly, the originator of mental health records may be a valuable source of clarifying, supplemental or contradictory information not available through a secondary source.

Second, and of greater concern purely from the standpoint of confidentiality, data banks of client-identified mental health information contain a great volume of information that can be used to injure, embarrass or discredit individuals. Obviously all compilations of such records, including paper files at mental health facilities have the same potential. But when confidential information is amassed from several facilities on a county-, region- or state-wide basis and it is computerized, a much more valuable and inviting target is created. Through the use of such computerized data banks, one can almost instantaneously obtain the records of vast numbers of individuals or canvass

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\*/ This point was made persuasively by Professor Charles Reich, Yale Law School, at the 196\_ hearings regarding the establishment of a federal government-wide data bank. See

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electronic data for the possible existence of records (and for the records themselves) on particular individuals or groups of individuals. Numerous examples of strong incentives so to abuse electronic mental health data banks come readily to mind. Prior to an election, it would be most advantageous to run a computer check on a slate of one party's candidates to determine whether any of them had ever been engaged in therapy. A large employer in a particular state might find it desirable to get readings from data banks as to whether any of its employees had been treated for mental conditions. A state or federal official might wish to find out whether any of a group of political dissidents has a history of mental disorder or mental health care which would be useful either to coerce one or more of them into silence or to discredit them. Private individuals or companies might wish to canvass such centralized records to obtain the names of government officials who might be susceptible to pressures arising out of threatened exposure as a former mental patient. To cite one further example, an employee with authorized access to vast quantities of mental health records might be tempted to market confidential information among unscrupulous persons whom he perceives as having some use for the information and as being unlikely to report his misfeasance.

We, as a nation, have certainly been exposed to sufficient experiences with the unethical use of various data banks in recent years to be wary of such possibilities. The records of journalists' telephone calls were provided to federal officials without notice to the individuals involved. Income tax records have been subjected to political uses. A former Director of the FBI has been accused of using the juvenile, criminal and arrest records of relatives of key members of congress as a means of exerting secret, improper influence over such legislators in connection with FBI appropriations. \*/ Of course the White House attempt to obtain the psychiatric records of Daniel Ellsberg by burglarizing his psychiatrist's office and the aborted Vice Presidential candidacy of Senator Eagleton, though apparently neither involved data banks, underscores the particular attractiveness of mental health records as a tool for suppressing or discrediting one's political enemies in our society.

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\*/ New York Times, April \_\_, 1974. Whether charges are true or not, the example serves an instructive purpose with regard to the potential abuses of masses of sensitive information.

The particular characteristics of computerized data banks which render them such a unique hazard to confidentiality and privacy are the volume of data that they contain, the speed with which they can be surveyed and the small number of people who need to be corrupted to obtain the data. By contrast, improper attempts to gain confidential information through individual facilities entails a much less efficient search, and a much more risky one in terms of the greater numbers of people who must be involved and the consequent likelihood that at least one of them will expose the intrusion.

The defenders of large data banks with individually identified mental health records respond by pointing to the value of such mechanisms in (a) permitting the follow-up on former mental health clients by making it possible to track them when they appear at other facilities, (b) eliminating the abuse of public mental health services by persons who obtain treatment particularly drugs, from more than one facility, (c) facilitating scientific research on the long-term benefits of treatment, and (d) providing a fuller accounting of the expenditure of public funds on mental health services. Proponents of such systems would also cite the possibility of constructing tight procedural and mechanical safeguards for the protection of the information stored in data banks and the deterrent effect of stiff civil and criminal penalties.

There are persuasive answers to these arguments. Individual facilities can perform the great bulk of follow-up with individual clients without resort to multi-facility data banks; and information about prior treatment is usually available through the client himself or through his family or friends. The issue in this regard eventually boils down to balancing the interests of obtaining prior records about the few individuals about whom such information cannot be obtained against the privacy interests of all who might be adversely affected by a system entailing data banks. In striking such a balance, one must also take into account the ability of current evaluation, diagnostic and treatment techniques to compensate for missing records and the interests of those individuals who would be deterred by the knowledge of a data bank operation from seeking help in a system that is tied into centralized computer operations.

The numbers of people abusing mental health facilities by seeking prescription drugs at several facilities is likely to be small and remedies short of data bank systems can provide some control. First, close attention to the symptoms and progress of persons on drugs that are particularly

susceptible to such abuses should expose many who are engaged in treatment in bad faith. Second, police investigations of illegal drug traffic in the community can expose other persons abusing the system. Third, blood tests of persons suspected of abusing drugs by overdosing themselves can detect still others. \*/

Research can gain most or nearly all the benefits of computerization through the use of anonymous compilations of data and the conduct of studies through the client-identified records available at local facilities. The two areas of research can be combined through the ability of the researcher to follow through significant trends in anonymous, aggregate data by careful analysis of individual cases at the facilities providing the data. \*\*/ Moreover, much valid research requires the careful design of the research project prior to the administration of any treatment and constant and careful monitoring of treatment at close range in order to avoid the influence of unknown variables that would taint the results. Multi-facility data banks would be unnecessary in such projects.

With regard to the notion of accountability of public health systems for services rendered at public expense, there are no significant perceived purposes served by the identification of individual clients in such accounting.

Finally, the creation of mechanical and procedural safeguards and the provision of harsh civil and criminal penalties for improper uses of data bank information are not seen as adequate precautions. Through expensive, sophisticated equipment, it is possible to thwart all but the most determined and knowledgeable efforts to penetrate a computer system. There are reports of most complex codes being broken and other mechanical protections being bypassed. This area, however, is not of prime concern. For

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\*/ A further precaution not here recommended, but which would be preferable to long-term storage of information in data banks, would be a system of regional recording of current clients for whom specific drugs are prescribed. All providers of treatment could check with such central data processing point before prescribing such drugs. At the end of treatment, or at such time as it is clear that the client is unlikely to engage in such abuse, the client's name and all other identifying data would be withdrawn.

\*\*/ No objection is made herein to electronically processed data being identifiable according to the provider of services. The concern is with data bank systems that involve the possible identification of individuals outside the facility at which he receives treatment.

assuming that the decision is made to spend the sums needed for relatively secure equipment, other real dangers exist.

No matter what the protective devices, human beings will have access to the information stored in data banks. Thus, there will always exist the possibility of unauthorized uses being made of such data either through the corruption or deception of the people who have authorized access. And no matter how severe the potential penalties, there will be occasions when the incentives are so strong and the perceived risks of detection so slight that unlawful misuse will be attempted.

Moreover, once the information is so readily available, there is the constant risk that stiff rules regarding disclosure will be relaxed. This might occur through an inadvertent legislative act or a change in the legislative view of the importance of confidentiality. An example of what could happen is the bill proposed in the Maine legislature in 1973 to give the state Attorney General access to the records of all public agencies for purposes of criminal investigations. The intent of the bill was apparently innocuous -- to spare the time, expense and effort incident to the use of subpoenas. Fortunately the state mental health authorities became aware of the proposal and they made a forceful argument against the measure. It was defeated. One cannot be certain, however, that, in a flurry of legislative activity, a bill with unforeseen repercussions for the confidentiality of mental health data banks might be passed or that a different balancing of interests, perhaps as a result of an event having a temporary effect on public opinion, might result in privacy interests being afforded less weight. As a consequence, confidential information originally computerized under rigorous standards may later come out under relaxed provisions.

The basic philosophy supporting the electronic data processing provisions set forth in the following statutory proposal is that governmental computerization of mental health services records should be controlled so as to maintain the pre-computer balance between confidentiality and efficiency. Thus, client-identified information is generally required to be kept at local mental health facilities. The transmission of client-specific information to outside computer operations is permitted only after individual-identifying data is removed; and the means of matching such data to individual is required to be kept at the service providing facility. This approach permits mental health facilities to use computer operations, with minimal added cost necessary to protect individual clients, for clinical, administrative and research purposes. It allows each hospital or center to use computers to produce



aggregate data that can be useful in the departmental and other evaluations of their efficiency and effectiveness. The significant inefficiency that it introduces is that detailed audits or inspections of the care of treatment provided in individual cases must be accomplished at the provider facility. In addition, this approach curtails inter-facility communications about clients without their authorization. On balance the interference with total unfettered use of client-identified information in data banks, which this approach curtails, attaches proper weight to the competing interests of efficiency and confidentiality. In the long run, the recommended scheme may have substantial advantages in terms of efficiency if it is credited with maintaining the confidence and trust of staff and clients in the information processing system.

PSYCHOTHERAPEUTIC CONFIDENTIALITY1. Definitions as Used in this Act:

## (a) "Authorized representative" means

(i) person empowered by the client to assert the confidentiality of information as established by this Act, but such person shall not, by virtue of being so empowered, have authority to waive confidentiality or to disclose, or consent to the disclosure of, confidential information;

(ii) if the client is incompetent to assert or waive his rights hereunder, a guardian or conservator who has previously been appointed or is appointed to act in place of the client, except that the nearest relative of such client may maintain the confidentiality until such time as such guardian or conservator has been appointed;

(iii) if the client is deceased, his personal representative or next of kin, or

(iv) the parent or guardian of a client who is less than fourteen years of age.

(b) "Client" means a person who is diagnosed or treated to some extent by a psychotherapist with regard to a mental or emotional condition;

## (c) "Client identifier" means

(i) the client's name or other descriptive data from which a person well acquainted with the client might with reasonable certainty recognize such client as the described person, or

(ii) a code, number or other means to be used to match the client with certain confidential information regarding him.

## (d) "Confidential information" means

(i) the fact that a person is or has been a client;

(ii) information transmitted in confidence between the client and psychotherapist in the course of diagnosis or treatment;

(iii) information relating to diagnosis or treatment transmitted in confidence between members of the client's family and the psychotherapist;

(iv) information relating to diagnosis or treatment transmitted between any of the persons specified in (c) (ii) and (iii) above and persons who participate in the accomplishment of the objectives of diagnosis or treatment under the supervision of or in cooperation with the psychotherapist;

(v) any diagnoses or opinions formed by the psychotherapist regarding the client's mental or emotional condition;

(vi) any advice, instructions or prescriptions issued by the psychotherapist in the course of diagnosis or treatment;

(vii) any summary, resume or characterization of the substance or any part of the information described in substance or any part of the information described in subsections (f) (i) through (v) of this section 1; and

(viii) any record, recording or notation of information described in subsection (f) (1) through (vi) of this section 1 in whatever form and by whatever means recorded or noted.

(e) "Diagnosis or treatment" includes observations made for purposes of diagnosis or treatment and all efforts to prevent, ameliorate or otherwise overcome the effects of mental or emotional disorders.

(f) "In confidence" means in a context wherein a person transmitting information does so by means which, so far as he is aware, discloses the information privately to the intended recipient and to no third persons other than:

(i) those who are present to further the interest of the client in diagnosis or treatment;

(ii) those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of diagnosis or treatment, including group therapy, and

(iii) persons reasonably believed to be regularly enrolled in a mental health care training program.

(g) "Mental or emotional conditions" include both normal and abnormal states and include alcoholism, drug dependence and mental or emotional conditions which may cause or be caused by physical disorders, provided, however, that such physical disorders themselves, other than those of the brain, shall not be considered mental or emotional conditions.

(h) "Mental health facility" means any hospital, clinic, office, nursing home, infirmary or similar structure at which the services of persons licensed to diagnose or treat mental or emotional conditions is provided.

(i) "Person" means any natural person, corporation, association, partnership, and any state, local or federal government or any agency or other part thereof including a court.

(j) "Psychotherapist" means any of the following persons while engaged in the diagnosis or treatment of a mental or emotional condition:

(i) a person who is authorized to practice medicine by any state or other duly constituted licensing authority under the laws of the United States or any other nation;

(ii) a psychologist trained and skilled in the diagnosis and treatment of mental disorders [licensed or certified to diagnose or treat mental disorders];

(iii) a person licensed as a clinical or psychiatric social worker;

(iv) a person licensed as a marriage, family or child counselor who, by virtue of such license, is authorized to use some psychotherapeutic measures; or

(v) any person reasonably believed by the client to be a psychotherapist within the meaning of subsections (c) (i) through (iv) of this section.

#### COMMENT

(a) "Authorized representative" is derived from the Connecticut statute. It has been refined to make it clear that a person empowered only to assert confidentiality does not have authority to cause the disclosure of confidential information. It also provides an authorized representative for persons under fourteen years of age.

(c) "client identifier" is an important concept under the statute. It is intended to include all means by which an individual could be identified in mental health information or records.

(d) "confidential information" is broader than the Connecticut definition of "communications and records." Specifically, it makes clear that the diagnoses, opinions, advice, instructions, and prescriptions of the psychotherapist are all covered by the act. Like the Connecticut statute, it also extends coverage to information transmitted in confidence between and among the client, psychotherapist, family members and other persons participating in the treatment of the client "under the supervision of or in cooperation with" the therapist." Modern treatment approaches often involve family members and other significant persons in the clients' lives in the therapeutic process. Also, the psychotherapist sometimes enlists the help of such people in adjusting the client's environment so as to enhance his



prospects for successful adjustment. Such efforts should not be hindered by a fear of a loss of confidentiality.

(f) "In confidence" is defined so as to clarify the inclusion of information disclosed both during group therapy and in the presence of other persons involved in the client's diagnosis or treatment or participating in a mental health care training program.

(j) "Psychotherapist" is a key definition. It includes medical doctors when they are engaged in the diagnosis or treatment of mental or emotional conditions. A very high percentage of mental health care services in this country are provided by non-psychiatric physicians; failure to protect mental health care information in that setting would be a gross oversight. Including psychologists, social workers and certain counselors within the definition of "psychotherapist" is based on the provisions of the California psychotherapist-patient privilege law. This approach is strongly recommended and each state legislature should consider having the inclusion of any persons licensed by the state to provide psychotherapy. At a minimum, psychologists should be included; for all practical purposes regarding needs for confidentiality the therapeutic techniques employed by psychologists are indistinguishable from those employed by psychiatrists.

Subsection (v) of the definition of "psychotherapist," is recommended so that confidentiality will not be lost simply because, without the client's knowledge, the therapist is not duly licensed.

## 2. Scope.

All confidential information shall be maintained in confidence and is subject to the provisions of this Act. Except as hereinafter provided, no person shall, without the authorization of the client, his authorized representative, (a) disclose or transmit any confidential information together with a client identifier to any person, (b) disclose or transmit a client identifier to any person, or (c) disclose or transmit confidential information to any person who the person disclosing or transmitting the confidential information has reason to believe may have a client identifier for such information.

### COMMENT:

This section extends coverage of the act to all confidential information as defined in section 1. The intention of the second sentence is to restrict the flow of confidential information that can be identified as pertaining to any particular individual.

It would thus not restrict statistical reports or case studies that are anonymous and well disguised. Further qualification of this principle is provided in subsequent sections.

This section also sets forth the broad general rule that the transmission or disclosure of confidential information is prohibited except where the authorization of the client or his authorized representative has been given.

### 3. Authorized Disclosures.

No authorization given for the transmission or disclosure of confidential information shall be effective unless it is in writing and signed, and specifies to what person such information may be transmitted or disclosed and to what use the transmitted or disclosed information may be put. Such specifications shall constitute the limits of the authorization. Every person requesting such authorization shall inform the client or authorized representative that refusal to give such authorization will in no way jeopardize his right to obtain present or future treatment except where and to the extent disclosure is necessary for treatment of said client or for the substantiation of a claim for payment from a person other than the client. The client or his authorized representative may withdraw any such authorization at any time in a writing transmitted to and received by the person authorized to receive such confidential information. Upon receipt of such withdrawal, the person previously authorized to receive said information shall exercise reasonable care in promptly notifying all persons who had previously transmitted information on the basis of said authorization, or who might reasonably be expected to do so in the future, that the prior authorization has been withdrawn. If authorization had been obtained by a person other than the person thereby authorized to receive said information, the person who obtained said authorization shall, upon request, promptly and in the exercise of reasonable care assist the client in ascertaining the correct name and address to which the withdrawal should be sent. Withdrawal of such authorization shall have no effect upon disclosures made prior hereto.

#### COMMENT:

This section requires that authorizations for disclosure be in writing and signed. By requiring that authorizations specify to whom information may be disclosed and the purposes to which the information may be put, it prevents the use of open-ended authorizations. Authorized recipients of confidential information thus obtain only a limited right to the information; they do not have authority to disclose the information further to other persons or to make uses of the information that the client has not intended.

Another important protection, patterned after that provided in the Connecticut statute, is that persons requesting authorization for disclosures of confidential information inform the client that his refusal will not jeopardize his right to treatment except insofar as disclosure is necessary for use in treatment or in obtaining reimbursement for treatment. This requirement puts the client in a better-informed position and thus should discourage attempts at over-reaching by persons who would extract authorizations for disclosure from clients under a false impression that such authorizations are necessary for them to participate in treatment.

The remaining provisions of this section are designed to provide assurance that a person who has given authorization will be able to withdraw it effectively at a later time. No one should be permanently bound by an authorization for confidential information to be disseminated.

4. Disclosures without authorization.

Authorization from the client shall not be required for the disclosure or transmission of confidential information in the following situations as specifically limited:

(a) Within the mental health facility: Confidential information may be disclosed to other individuals employed at the mental health facility when and to the extent of the performance of their duties in employment requires that they have access to such information. For purposes of this subsection (a), (i) persons enrolled in good faith in mental health care training programs at said mental health facility are to be considered as being employed at said mental health facility, and to the extent reasonably required in their training to have duties requiring that they have access to such records or information, but (ii) individuals employed at the mental health facility and involved in preparing bills or otherwise engaged in the collection of charges for services to a client shall not, by virtue thereof alone, be considered as having such duties except with respect to names, addresses and other information essential to the preparation and submission of bills and claims for payment of charges for services to a client.

(b) Protection from serious injury or disease: Confidential information may be disclosed when and to the extent the treating or diagnosing psychotherapist determines that such disclosure is necessary to protect, through civil commitment

proceedings or otherwise, against a clear and subsequent risk of imminent serious physical injury or disease or death being inflicted by the client on himself or another. Failure to make such disclosure, however, shall not subject such psychotherapist to any form of liability.

(c) Billing and claims: Psychotherapists who hold themselves out as persons engaged primarily in the diagnosis or treatment of mental or emotional conditions shall not use the services of persons, other than those directly employed at the mental health facility at which services are provided and attorneys-at-law, in the billing for and collection of charges from either the client or persons legally responsible for services rendered to the client by virtue of family relationship or guardianship, unless and until three requests for payment have been delivered or mailed at at least 21 day intervals, 90 days have expired since the first such bill was delivered or mailed and 30 days have expired since a notice regarding intended referral of the bill or claim was delivered or mailed. In any event and in the cases of all psychotherapists, information supplied to persons involved in the billing for or collection of charges for diagnostic and treatment services, other than those persons mentioned in the preceding sentence shall be limited to names, addresses, dates on which services were performed and the amount of charges for such services and shall not otherwise indicate that the services were for the diagnosis or treatment of mental or emotional condition. In the event of a claim in any civil action for payment for the diagnosis or treatment of mental or emotional condition, no other confidential information except names, addresses, the dates on which services were rendered and the amount of charges for such services shall be disclosed in pleadings and motions except to the extent necessary (i) to respond to a motion of the client for greater specificity or (ii) to dispute a defense or counter claim.

(d) Client-Litigant Exception.

(i) Confidential information may be disclosed in a civil or administrative proceeding in which the client introduces his mental or emotional condition or any aspect of his diagnosis or treatment for such a condition as an element of his claim or defense if and to the extent the court in which the proceedings have been brought, or, in the case of an administrative proceeding, the court to which an appeal, or other action for review of, an administrative determination may be taken, finds, after in camera examination of the testimony or other evidence, that it is relevant, probative, not unduly prejudicial or inflammatory, and otherwise clearly admissible; that other satisfactory evidence, such as the results of a present examination of



the client or stipulations of fact between the parties, are demonstrably unsatisfactory as evidence of the facts sought to be established by such evidence and that disclosure is more important to the interests of substantial justice than protection from injury to the psychotherapist-client relationship or to the client or others which disclosure is likely to cause. The preceding sentence shall not apply to divorce actions or to damage claims for pain and suffering that do not include a claim for the services of a psychotherapist or for an abnormal mental or emotional condition

(ii) Confidential information or records may be disclosed in a civil proceeding after the client's death when the client's mental condition has been introduced as an element of a claim or defense by any party claiming or defending through or as a beneficiary of the client provided the court finds, after in camera examination of the evidence that it is relevant, probative, and otherwise clearly admissible; that other satisfactory evidence, including stipulations of fact between the parties, is not available regarding the facts sought to be established by such evidence; and that disclosure is more important to the interests of substantial justice than protection from any injury which disclosure is likely to cause.

(iii) In the event of a claim made or an action filed by a client, or, following the client's death by any party claiming as a beneficiary of the client, for injury caused in the course of diagnosis or treatment of said client, the psychotherapist and other persons whose actions are alleged to have been the cause of injury may disclose pertinent confidential information to an attorney or attorneys engaged to render advice about and to provide representation in connection with such matter and to persons working under the supervision of such attorney or attorneys, for the purpose of preparing and presenting a defense against such claim or action.

- (e) Court-ordered examination. Communications made to or diagnoses and opinions made by a psychotherapist in the course of a mental examination ordered by a court for good cause shown may, if otherwise relevant and admissible, be disclosed at judicial or administrative proceedings in which the client is a party or in appropriate pretrial proceedings provided such court has found that the patient has been as adequately and as effectively as possible informed before submitting to such examination that such communications, diagnoses and opinions would not be considered confidential or privileged, provided that such communications, diagnoses and opinions shall be admissible only on issues involving the client's mental condition.

COMMENT:

This section sets forth five areas in which disclosure is permissible without written authorization from a client. These are exceptions in generally only a technical sense because in most instances the individual will be in control of the information.

(a) Within mental health facilities: This subsection eliminates a cumbersome requirement for people within a mental health facility to exchange and obtain authorizations for disclosure of information about individuals. It thus facilitates team approaches to treatment and a wide variety of informal consultations between therapists. It also allows information to flow to all those at the facility who need information in the course of their dealings with individual clients. It does not, however, permit information to flow indiscriminately without justifiable reasons. Specific protection is set forth so that persons employed for billing purposes should not, in connection with such duties, receive any information other than that necessary for them to make out and send bills and receive payment.

(b) Protection from serious injury or disease: Despite solicitude for confidentiality and the recognized fallibility of mental health professionals in predicting dangerous behavior, it seems preferable to permit a psychotherapist to disclose confidential information when and to the extent he deems it necessary in order to prevent serious physical harm. Otherwise a psychotherapist would risk civil, criminal or disciplinary action in acting to prevent injury.

This section is permissive only. No requirement to disclose in such circumstances should exist. If it did, were confidentiality would be seriously vitiated. Often the voicing of threats, anger and frustration in therapy relieve the tension that could lead to violence; and the judgments whether threats are real or past violent actions are likely to be repeated are extremely subjective and uncertain.

(c) Billing: This paragraph seeks to achieve an accommodation between the individual's right to privacy and the rights of mental health services providers to seek payment. The use of outside agencies by mental health services providers to collect their bills is prohibited, at least until after their own in-house efforts have proven unsuccessful. The routine use of outside collection agencies by persons and agencies known as mental health care providers involves an unnecessary and potentially harmful dissemination of information about individuals as mental health clients and creates small registers of mental health service clients. Restrictions are also placed on the amount of information which may be provided to persons involved in bill collecting so as to guard against unnecessary or undue stigmatization, embarrassment and pressure.

The purposes for allowing persons who hold themselves out as providers of psychotherapeutic services to seek immediate recourse to attorneys-at-law in collecting bills are that lawyers should be aware of confidentiality laws and accustomed to protecting privileged information and that occasionally it may be necessary for claims to be submitted in bankruptcy, decedents' estates and other legal proceedings with time limitations for the filing of claims.

In the event of litigation involving a claim for psychotherapeutic services, this section places restrictions on the kinds of information that need to be disclosed unless, through denial or otherwise the client or his authorized representative creates a particular need for further disclosure of confidential information.

(d) Client-litigant exception: Some statutes that provide for a psychiatrist-patient or psychotherapist-client privilege include a broad exception for cases in which the patient or client has raised his mental or emotional condition as a claim or defense. The general rationale for the exception is to prevent the shield of confidentiality from becoming a sword of unfair advantage by allowing the individual to put his mental or emotional condition into issue and then to prevent relevant information about it from being disclosed. While this rationale is commonsensical, as a broad exception it has proven to be susceptible to abuse and to be unnecessarily expansive. One complaint is that people with meritorious claims may be forced to withdraw them in the face of threats to force disclosure of sensitive or embarrassing information during pre-trial discovery or in the courtroom. Also, the argument can be made that an overly broad client-litigant exception unconstitutionally forces people with just claims to waive their right to privacy as a condition of seeking legal redress.

Thus, a number of safeguards have been incorporated in the present version of the exception so that intrusions upon confidential information are made only when absolutely necessary, and then only when the court finds that the interests of achieving justice supersede any possible harm that would flow from disclosure. Thus, before any disclosure takes place, a judge must find in private proceedings in his chambers that the proposed testimony or evidence is relevant, probative, not unduly prejudicial or inflammatory, and otherwise clearly admissible. These are ordinary requirements regarding the admissibility of evidence. They are set forth here in order to highlight their special applicability in this situation and to guard against pre-trial disclosure of information that would not subsequently be admissible at the trial.

The court must also determine that no other satisfactory evidence exists to establish the facts sought to be shown through confidential information. In many cases a current mental examination of the client will suffice to show the nature, extent and cause of mental or emotional disorder. Also, it may frequently be the case that the parties can stipulate to certain facts and thus avoid the need to resort to confidential information. The court can be expected to encourage parties to take this route.

If the court still determines that the disclosure of confidential information is admissible and necessary to prove relevant facts, it must finally determine that the "interests of substantial justice" in the case are more important than protection from injury that may be caused by the disclosure of the information.

The final sentence of this subsection permits no exceptions in divorce cases. This recommendation arises out of the experience in Illinois, where it was found that the exception was discouraging married persons from seeking psychotherapeutic help with regard to marital or sexual problems because of the fear that a subsequent divorce action might result in disclosure of their confidences. The Illinois position makes good sense and is thus included here. Claims for "pain and suffering" are also expressly excluded. This is simply a clarification to insure that the phrase "mental and emotional condition" is not broadly interpreted to include the ordinary claims for pain and suffering which personal injury claimants assert. Without this clarification, defendants in personal injury cases would have at least a marginally credible threat of forcing disclosure of confidential information as a means of coercing personal injury claimants into dropping their claims.

It should also be noted that this exception has been worded broadly enough to encompass cases, such as malpractice actions against psychotherapists, in which the treatment received by the client has been placed in issue by him.

Confidentiality is protected after the client's death in recognition of the fact that people may be dissuaded from engaging in mental health care or being fully candid during treatment out of a fear that all such information could easily be disclosed after their deaths.

(e) Court-ordered examination: This subsection merely clarifies what would be obvious in the context of a court-ordered examination administered for the purpose of producing information for use in judicial or administrative proceedings, i.e., that such examinations and the results of them are not confidential in that the results of them may be admitted in evidence on issues involving the individual's mental condition. It should be noted, however, that this subsection does not create positive authority for the conduct of such examinations. That authority must derive from other statutes.



## 5. Waiver.

- (a) Particular items of confidential information may be disclosed in judicial or administrative proceedings if the court in which the proceedings have been brought or, in the case of an administrative proceeding, the court to which an appeal from an administrative determination may be taken, finds that the information is relevant and otherwise admissible and that the client or his authorized representative has, without coercion, knowingly waived confidentiality by disclosing, or consenting to disclosure of, the substance of such particular information.
- (b) Disclosures that are privileged, disclosures made in the course of obtaining payment for treatment and related services, and disclosures made in the interest of accomplishing a purpose for which the psychotherapist was consulted are not waivers of confidentiality.
- (c) Consent to disclosure for purposes of this section 5 includes a failure by the client or his authorized representative to assert the confidentiality of information in any proceeding in which he has the legal standing and opportunity to do so.

### COMMENT:

This section is patterned after the California law regarding the waiver of the psychotherapist-patient privilege. It allows adversary parties to introduce confidential information when the individual to whom it pertains or his authorized representative has previously, voluntarily disclosed or consented to disclosure of the substance of such information. It should be noted that waiver occurs only with regard to particular items of such information and that disclosure of one piece of information is not tantamount to a waiver of all confidential information about the client.

## 6. Rulings on claims of confidentiality.

- (a) In a ruling on an assertion of confidentiality to prevent disclosure in judicial or administrative proceedings, the court may not require disclosure of information asserted to be confidential under the Act in order to rule on such assertion.
- (b) When neither the client nor his authorized representative are parties to an administrative or judicial proceeding or they otherwise lack the opportunity to assert confidentiality:
  - (i) any person asked in administrative or judicial proceedings to disclose confidential information may assert its confidentiality; and
  - (ii) the presiding officer on his own motion or

the motion of any party shall exclude such information. Such presiding officer may not exclude information under this section 6 if (i) he is otherwise instructed by the client or his authorized representative to permit disclosure; or (ii) the proponent of the evidence establishes that there is no person authorized to assert confidentiality in existence.

(c) Whenever confidentiality is asserted under this Act in a judicial or administrative proceeding, the party opposing such assertion shall have both the burden of going forward with evidence and the burden of proof with regard to issues of whether confidentiality has been waived and whether any relevant transmissions of information were not made in confidence.

(d) No person shall be held in contempt for failure to disclose confidential information unless he has failed to comply with a court order that he disclose such information.

COMMENT:

This section also is patterned after California law. It provides that in order to assert confidentiality, one need not disclose the information he is seeking to protect. It provides for the assertion of confidentiality in proceedings in which the client and his authorized representative are not participants. It also places the burden on any party disputing a claim of confidentiality to prove waiver or to prove that relevant information was not given "in confidence". Finally, it makes it clear that only a court can compel disclosure of confidential information. Thus, in administrative proceedings, the disclosure could not be compelled without a court order being obtained. Under the California law, certain administrative agencies having subpoena power are given authority to compel disclosure of confidential information on pain of a finding of contempt. The recommendation here is that all such matters should be referred to a court of law.

7. Prescriptions. Nothing in this Act shall be construed as limiting or interfering with state and federal programs established pursuant to law for regulating and monitoring the handling and dispensing of prescription drugs. Otherwise, however, prescriptions for psychotropic drugs shall be considered confidential information and subject to the provision of this Act.

COMMENT:

Prescriptions issued by psychotherapists are included within the definition of confidential information. This section reinforces that position but allows for such handling of records of prescriptions as are necessary to conform with state and federal laws regulating prescription drugs.

8. Research. Persons engaged in research may have access to confidential information which identifies clients where needed for such research, provided no records thereof shall be removed from the mental health facility which prepared them. Data which does not identify clients or coded data may be removed from a mental health facility provided the key to such code shall remain on the premises of the facility and no copies thereof are removed. Where the person engaged in research is to have access to confidential information, the research plan first shall be submitted to, and approved by, the director of the mental health facility or his designee. The mental health facility, together with the person doing the research, shall be responsible for the preservation of the anonymity of the clients and shall not disseminate data which identifies a client except as provided by this Act.

COMMENT:

This provision is closely patterned after the section of the Connecticut confidentiality statute governing research. A requirement that researchers obtain authorizations from each client would unduly burden research efforts. Thus, the emphasis of the approach set forth above is on requiring researchers and heads of mental health facilities to protect the anonymity of mental health clients in the work and publications of researchers.

9. Mandatory Cautions.

(a) All non-oral disclosures of confidential information shall bear the following statement: "The protection of the confidentiality of information contained herein is required under [chapter ] of laws of the State of [ ], which provides for civil damages and criminal penalties for violations. This material shall not be transmitted to anyone without consent or other authorization as provided in the aforementioned statute." A copy of the pertinent consent form specifying to whom and for what specific use such communication or record is disclosed or transmitted, or a statement setting forth any other statutory authorization for disclosure or transmittal and limitations imposed thereon, shall accompany all such non-oral disclosures. In cases of oral disclosure, the person disclosing confidential information shall inform the recipient that such information is confidential under the laws of this state.

(b) Psychotherapists shall insure that all persons in their employ or under their supervision are aware of their responsibilities to maintain the confidentiality of information protected by this act and of the existence of criminal and civil liabilities for violations of this Act.

COMMENT:

This provision also is taken from the Connecticut statute. It is calculated to perform the valuable function of placing recipients of confidential information on notice as to the strict requirements of this law and the civil and criminal penalties for violations.

10. Civil Remedies. Any person aggrieved by a violation of this Act may petition the [ ] court for the county in which he or the defendant resides or in which such violation occurred, for appropriate relief, including temporary and permanent injunctions, and such petition shall be privileged with respect to assignment for trial. Such aggrieved person may also prove a cause of action for general or special damages, or both, and, in cases of willful or grossly negligent violations, punitive [exemplary] damages.

COMMENT:

Provision is made for obtaining injunctions against violations of this act, a remedy that is obviously wholly in keeping with the spirit and purposes of this act. With regard to damages, the intention is that general damages can be recovered for violations without a specific showing of special damages.

11. Criminal Penalties.

(a) Violations of this Act caused by simple negligence shall be punishable as misdemeanors pursuant to [relevant statute].

(b) A willful or grossly negligent violation of this Act, shall be punishable by a fine not to exceed \$5,000 or imprisonment not to exceed 30 days or both. For purposes of this section, in cases of willful disclosure of confidential information, each such disclosure of information pertaining to any one person to any other natural person shall constitute a separate violation.

COMMENT:

The intention of the final sentence of this section is that willful disclosure of information about one person to ten other persons constitutes ten violations and that a disclosure of information about five individuals to five other persons constitutes 25 violations.



## 12. Employee Discipline.

(a) Any state, county or local government employee and any employee of a mental health facility operated under contract to a state, county or local government or department or agency thereof who repeatedly, willfully or through gross negligence violates this Act, shall be dismissed from employment, or, in the case of mitigating circumstances deemed adequate by the employer, appropriately disciplined and transferred to a position, if available and otherwise suitable, outside a mental health facility and involving no access to confidential information.

(b) Negligent, non-repetitive violations of this Act shall render such employees subject to appropriate disciplinary action.

(c) In the course of any disciplinary or dismissal actions against such employees, confidential information shall not be used except to the extent necessary to comply with principles of fair notice and hearing, and client identifiers shall be removed from any such information prior to its use in such proceedings.

(d) All contracts between private persons and any state, county or local government or department or agency thereof involving access by such private persons or their employees, representatives, agents or subcontractors shall include a provision setting forth the requirements of this section. The absence of this clause from any such contract shall not have any effect upon the effectiveness of this section.

## 13. Client Access to Information to be Disclosed

(a) Prior to the honoring of any request for confidential information pursuant to an authorization as specified in section 3 of this Act, the client, his guardian or, if the client is less than 14 years of age, his parent or guardian, shall have the right (i) to receive the notice provided for in subsection (b) of this section 13, and (ii) to examine and to obtain copies of any disclosures proposed to be made pursuant to such request and to be informed of the substance of any such oral disclosures.

(b) Prior to honoring any request for confidential information pursuant to an authorization as specified in section 3 of this act, a mental health facility shall not provide such information less than two weeks after it has delivered or mailed to the client, or his guardian or, if the client is less than 14 years of age, to his parent or guardian, a written notice advising of (i) the request, and the date on which disclosure is proposed to be made pursuant to such request, (ii) the rights set forth in subsection (a)(ii) of this section 13 and the right to withdraw his

authorization for disclosure and (iii) of the name, address and telephone number of the person or persons the client can contact in order to examine such information and obtain a copy thereof. A copy of the authorization and of the request for disclosure shall be attached to or enclosed with such notice.

(c) Section 13 shall not apply to requests for confidential information pursuant to authorization as specified in section 3 of this act when such requests are:

(i) made by a physician, licensed [or certified] psychologist or attorney-at-law who asserts that he has been retained to provide professional services to the client;

(ii) made by an attorney-at-law who asserts that he is an attorney for the client's guardian or, if the client is less than 14 years of age, for the client's parent or guardian; or

(iii) limited to names, addresses, dates on which services were performed and the amounts of charges for services.

(d) Any person having received confidential information pursuant to an authorization for disclosure shall make such information available and provide copies thereof upon receipt of reimbursement for reasonable copying charges to the client to whom such information pertains, the guardian of such person, and the parent of such person if he is less than 14 years of age upon request. [This subsection 13(d) shall not, however, apply to personal notes of a psychotherapist which have been disclosed to a physician or psychotherapist pursuant to Section 18 of this Act.] Upon request, the holder of such information shall permit the pertinent client or his guardian or, if he is less than 14 years of age, his parent, to submit clarifying or correcting statements and other documentation of reasonable length for inclusion with the confidential information. Such remarks, statements and other documentation shall be kept with the relevant confidential information, shall accompany it in the event of disclosures and shall be governed by the provisions of this Act to the extent they contain confidential information.

COMMENT:

The question whether mental health services clients should be permitted access to their mental health care records generally is debated elsewhere. Such clients should, at a minimum, be able fully to apprise themselves of information about themselves being disseminated outside mental health care channels. Accordingly, this section gives such clients access to any information that will be, or has been, disclosed pursuant to their authorization to outside persons. Given this opportunity, prior to dissemination of information, mental health care clients will have the

opportunity to verify the accuracy of information being so disclosed, to challenge disclosures as being outside or beyond their authorization, and, when they see fit, to withdraw their authorization and accept the alternative consequences.

Exceptions to the two-week opportunity to examine information to be disclosed are made for disclosures to the doctors, psychologists and lawyers of clients. These professionals occupy a clear relationship of trust with the client and their needs for the information frequently require more expeditious disclosure than the two-week delay would permit. Likewise, routine billing-type information may be disclosed without compliance with these rigorous provisions. This exception is based on the assumption that the client has little need or interest in reviewing this information before it is disseminated to previously authorized persons.

After disclosure, the client should have full opportunity to know what information was disseminated about him. Among the major evils of clearinghouses, dossiers and data banks containing personal and confidential information is that they frequently provide the basis for adverse action against individuals, which actions they cannot meaningfully contest, challenge or even understand because they are denied access to the information on which it is based. Similarly, much of the information disseminated, but kept secret from the people to whom it pertains is erroneous or susceptible to misinterpretation because, ignorant of its substance, the individual is unable to have it corrected or removed. Accordingly, subsection (d) provides reasonable recourse to the client to examine the information and to have his clarifications or corrections included in his files.

#### 14. Group Health and Life Insurance

Information regarding medical and mental health history, condition and treatment on group health and group life insurance applications, questionnaires and claim forms to be submitted to an insurance company regarding the insurance coverage of a resident of this state shall be submitted directly by insured or covered persons and by providers of covered health care services to the insurance company, and no person shall demand or request the same or any copy thereof, or information therefrom, to be submitted to or through any member or representative of the group, or to or through the employer or any representative or agent of the employer of the persons covered by such policy. Insurance companies with group policies covering persons residing in this state and the representatives and agents of such companies, in accordance with rules and regulations to be promulgated by the

Commissioner of Insurance, shall, within 120 days from the effective date of this act (a) take measures to assure that group members, employers of group members and representatives and agents of such employers involved in the administration of such policies are advised of the requirements of this section; (b) cause notices regarding this section to be printed prominently on all such policies, on printed materials intended to be provided to group members and their employers regarding such policies and on all applications, questionnaires, claims and similar forms to be submitted by or on behalf of covered persons and by persons providing covered health care services. For purposes of this section, covered health care services shall include diagnostic and evaluative services. This section shall not apply to applications for life insurance benefit payments.

COMMENT:

Employees covered by group health insurance should not have to choose between insurance coverage and confidentiality. Yet that is precisely their choice when the processing of insurance claims and other insurance forms entails employer access to sensitive information. It is obvious that many employees would choose either to forego treatment or to pay for it out of personal funds rather than provide their employers with information about their own or their family members' abortions, mental disorders, venereal disease or various other problems. Employer access to such information can lead to firings, demotions, suspensions or to subtle or disguised discrimination or ostracization. Employers can be kept informed of total costs of care and treatment and insurers can be kept apprised of the names of persons covered through employment without the employer knowing clinical facts which may injure individual employees.

15. Health and Life Insurance; Prohibition on Requirement of Consent to Disclosure by Insurance Company to Others.

No insurance company or any employee, representative or agent thereof shall require of any person residing in this state as a condition of the issuance, continuation, renewal or reinstatement of a life, health, accident, medical, hospitalization or similar insurance policy or as a condition of paying any benefits thereunder that an applicant, insured or covered person, or any person acting in his behalf, authorize or agree to authorize such insurance company to disclose confidential information with client identifiers to persons other than itself. Advice that no such requirement may lawfully be imposed must be given in conjunction with any request for such authorization.



COMMENT:

The Medical Information Bureau (MIB), a clearinghouse operation which services some 760 life insurance companies, some of which also issue health insurance, has medical background information, including psychiatric and nervous disorders, on more than 12 million people. Its data bank is expanding at the rate of about 400,000 people each year. MIB receives medical information about applicants and policy holders from insurers and it supplies "alerts", upon request, to participating companies for their use in evaluating applications and claims. According to MIB rules, such "alerts" are limited to notification that persons, about whom an insurance company has requested information, have reportedly experienced certain illnesses in the past; participating companies are not supposed to deny applications or claims solely on the basis of "alerts." Rather they are to make their own independent investigations and base their determinations on such investigations. How vigorously and extensively MIB enforces these rules against itself and the companies which support it is unknown.

The purpose of the MIB system is to help insurance companies protect themselves against applicants and claimants who fraudulently or negligently fail to disclose past health care to insurers. There are smaller systems than MIB providing the same type of service.

The existence of such massive computerized data banks including mental health information represents a deplorable imbalance between individual privacy and business needs. Whatever relationship there may be between mental or emotional disorder and life expectancy would not justify the inclusion of mental health information in such a system. \*/

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\*/ Whether such a system, to the extent that it includes non-mental, medical history, should exist at all is beyond the scope of this work. It has been sharply and properly criticized as a secret operation. Individuals should at least know that information about them is included in such data banks and have access to whatever information is so recorded. This section's prohibition against insurance companies requiring individuals to authorize them to pass confidential information on to other persons should effectively preclude the growth and continuation of inclusion of mental health information in these and similar systems.

16. State, County and Local Information Systems.

(a) Official inspections: Nothing in this act shall be construed as prohibiting any state, county or local government official from performing any audits, investigations or inspections of mental health facilities in the state as required or authorized by law, provided that the performance of such duties shall not entail removal from any such facility any confidential information with client identifiers or any codes or keys to electronically processed information.

(b) Statistical reports: Nothing in this act shall be construed as prohibiting the issuance of statistical reports and similar anonymous data regarding the operations of mental health facilities.

(c) Electronic Data Processing:

(i) No confidential information with client identifiers regarding any client of a mental health facility shall be recorded outside such facility on electronic data processing equipment operated by or for a state, county or local government or any department or agency thereof, except in accordance with this subsection (c) of this section 16.

(ii) In order to facilitate the treatment of current clients of a mental health facility, said facility may cause information regarding such clients to be recorded on electronic data processing equipment, provided that such information shall be encoded and shall contain no client identifiers except for symbolic identifiers, and the key to such encoding and the symbols by which information may be matched to clients shall at all times be kept secure on the premises of the mental health facility by data processing personnel under the direct supervision of the director of such facility. Such key and symbolic identifiers shall under no circumstances be disclosed to any person other than the personnel responsible for data processing at said facility except as provided in subsection (c)(iv) of this section 16. In the event (A) unauthorized persons have gained access to the key or the symbolic identifiers, (B) it appears to the director of the facility that unauthorized persons might have gained such access and a possibility of compromise of the information exists, or (C) disclosure of keys or symbolic identifiers is required in connection with any disciplinary, civil or criminal action, the key or symbolic identifiers, as appropriate, shall be changed so that any person with the former key or symbolic identifiers shall be unable thereby to identify any client to whom the electronically stored data pertains. Symbolic identifiers may be a series of letters or numbers or other symbols and shall be so designed as to be unique to the mental health facility and unknowable to other persons.

(iii) No more than [90] days after a client has completed or withdrawn from diagnosis, treatment, care and rehabilitation at a mental health facility, all records and other means by which a symbolic identifier can be used to match electronic data containing confidential information regarding said client shall be destroyed by electronic data processing personnel at such facility.

(iv) Keys and symbolic identifiers as described in subsection (c(ii)) of this section 16 may be disclosed (A) to the extent necessary for auditors regularly employed by state, county or local government to inspect electronic data processing equipment to insure strict and complete compliance with this act, provided that such inspections shall not involve the removal of such keys and identifiers, or copies thereof, from a mental health facility, (B) to the extent required for a fair hearing in connection with the dismissal or discipline of an employee charged with violating this act, and (C) to the extent necessary for use in civil or criminal actions arising out of violations of this act.

(d) Indigency investigations: Any agency of state, county or local government charged with responsibility to investigate or audit claims of indigency, hardship or similar status whereby individuals may receive mental health care services [and services of the Mental Health Advocacy Service] without charge or on the basis of reduced charges, shall maintain the confidentiality of the clients in the conduct of such investigations or audits and, upon the completion thereof, shall forward a report to the facility or agency for whom it was prepared and shall keep no record of such investigation by which the client can be identified.

COMMENT:

(a) Official inspections: Inspections of mental health facilities can be accomplished and reports on such inspections can be performed without the disclosure of individual client identity beyond the persons doing the inspecting. The purpose of this section is to make clear first that this act is not intended to interfere with legitimate inspections and second that such inspections should not compromise the protection of confidential information.

(b) Statistical reports: This subsection states the obvious out of an abundance of caution, lest the opponents of strict confidentiality overstate the strictures which this act would impose.

(d) Electronic data processing: This subsection employs the approach described at pages through of the introductory

materials. Essentially, it is designed to keep client-identified confidential information at the local mental health facility level and thus prevent governmental data-banking of such information from several facilities. It should be noted that in addition to removal of client-identifiers prior to transmission of confidential information, this subsection requires that the information be "scrambled" by an encoding mechanism at the facility. This would discourage attempts to gain information about particular individuals at a central computer facility by means such as scanning according to the dates of admission or other pieces of information that an unauthorized person may have about the care or treatment of particular persons.

(d) The purpose of this subsection is to help insure that mental health client registers are not compiled outside mental health channels. There may be other agencies in a given state that provide supporting services to mental health facilities in such a fashion that their records of services produce listings of mental health clients. If so, the operations of such agencies should be governed by a similar provision.

Alternative Provision for Electronic Data Processing  
by Mental Health Facilities.

(a) No electronically processed data of confidential information with client identifiers shall be recorded on equipment outside a mental health facility except in accordance with this section.

(b) Confidential information regarding current clients may be recorded on electronic data processing equipment outside a mental health facility only if

(i) such information is encoded by means which make it impossible for persons other than data processing personnel within such facility to discern the identity of individual clients;

(ii) the encoding means or devices by which a client can be identified are delivered, within 60 days after a client is discharged or otherwise ceases to participate in diagnosis or treatment, by data processing personnel within such facility to a person or persons under the direct supervision of the facility director, which person or persons are strictly denied access to the electronic data processing equipment and are responsible for the safekeeping of such encoding means or devices and the denial of access thereto to all persons except as provided in subsection (6)(iii) of this section \_\_\_\_;



(iii) the encoding means or devices by which a former client can be identified may be returned to data processing personnel for purposes of reactivating access to confidential information stored on electronic data processing equipment when, and only when, (A) the client to which such information pertains has reentered diagnosis or treatment at such facility, or (B) a request for confidential information which may be honored under the provisions of this act has been received; and

(iv) no later than three years after a client has been discharged or has otherwise ceased to participate in diagnosis or treatment at such facility, either said encoding means or devices pertaining to such client shall be destroyed or all electronically processed data pertaining to such client shall be returned to data processing personnel at such facility.

(c) Such encoding means or devices may be disclosed (i) to the extent necessary for auditors regularly employed by the state to inspect electronic data equipment to insure strict and complete compliance with this act, provided that such inspections shall not involve the removal of such encoding means and devices, or copies or other reproductions thereof from a mental health facility, (ii) to the extent required for a fair hearing in connection with the dismissal of an employee charged with violating this act, and (iii) to the extent necessary for use in a civil or criminal action arising out of violations of this act.

(d) This section does not apply to electronic processing of data concerning persons covered by medical or other health insurance by an insurance company providing such coverage to such specific individuals, provided such company is periodically audited in accordance with regulations promulgated by the commissioner of insurance to assure strict and complete adherence to the provisions of this act.

COMMENT:

Section 16(c) governs public mental health information systems. This alternative provision would regulate all electronic data processing of mental health data. It employs the same basic approach of keeping the client-identifying capability at the individual mental health facility. It employs additional techniques for safeguarding client-identifiers within the mental health facility.

Note that subsection (d) provides some means to prevent abuse by or through insurance companies. In general it must be admitted that this proposed legislation does deal extensively

with the problem of data banks within insurance companies. \*/  
More attention needs to be given the troublesome problem of regulating the flow of confidential information to insurance companies and their handling of it in a manner consistent with their need for detailed information.

17. Disclosures Required in Federally Funded Programs.

(a) Confidential information may be disclosed to federal departments and agencies to the extent required under federal law (i) to obtain reimbursement for diagnosis, treatment and other mental health care services under federally funded programs and (ii) to conform to legally constituted programs for review and audit which are a requisite for participation in federally funded programs.

(b) Any organization or agency designated under federal law to perform such reviews or audits of the cases of clients who are residents of this state shall maintain the confidentiality of confidential information, shall not disclose confidential information except to the extent required by federal law, and shall destroy the means by which clients can be identified in such information and records containing such information at the earliest opportunities consistent with the requirements of federal law.

(c) To ensure that confidential information regarding citizens and residents of this state is afforded maximum protection consistent with the provisions of this act, the [Commissioner of Mental Health] shall promulgate regulations that specify the minimum information required pursuant to subsections (a) and (b) of this section 17 and disclosures in excess thereof shall constitute violations of this act. In the event a demand for confidential information in excess of that provided for in such regulations is made upon any mental health facility in this state upon pain of disallowance of reimbursement or other benefits, such facility shall immediately refer the matter to the [Commissioner of Mental Health] or his designee who shall, on behalf of such facility, obtain a resolution of the matter either by negotiation or appropriate court action, or by advising said facility that disclosure is required under federal law. Disclosures pursuant to the preceding sentence shall not constitute violations of this act if all reasonable measures to assure confidentiality are taken. Pursuant to regulations adopted by the [Commissioner of Mental Health], any mental health facility, other than one operated

\*/ A reasonable approach, however, is proposed to deal with data banks created among insurance companies. See section 15, supra.

by the state, shall be reimbursed by the [Department of Mental Health] for any claims for reimbursement under federally funded programs which are denied as a result of prompt compliance with this section.

(d) The [Commissioner of Mental Health] shall prepare written notices describing the requirements under any federally funded programs for the disclosure of confidential information with client identifiers, the nature of the information to be disclosed, the persons and agencies who will have access to such information and the purposes for such access; and he shall promulgate regulations establishing procedures whereby each person being provided care or other services for which reimbursement will be sought through a federally funded program involving such disclosure will be given such notice at the outset of the delivery of services. Such notices shall provide advice regarding the individual's option not to receive treatment on a basis whereunder such disclosures are required.

COMMENT:

Federal programs have the potential for creating data bank operations that would dwarf state and private systems, but federal legislation is beyond the scope of this material. It is recommended, however, that states assume responsibility for protecting the privacy and confidentiality interests of their citizens by ensuring that federal administrators extract no more client-identified information than is properly required under federal law. The approach here recommended is rigorous and, perhaps, unduly cumbersome to impose on private providers of mental health care services. Accordingly, it may be advisable to limit its scope to public facilities. If that is done, the information supplied by public facilities could serve as a guide to private facilities and practitioners.

18. Personal Notes; Special Limitations on Disclosure (Optional)

(a) A psychotherapist may, to the extent he determines it necessary and appropriate, keep personal notes regarding a client wherein he may record (i) sensitive information disclosed to him in confidence by other persons on condition that such information would never be disclosed to the client or other persons excepting, at most, other physicians or psychotherapists, (ii) sensitive information disclosed to him by the client that would be injurious to the client's relationships to other persons to disclose, and (iii) the psychotherapist's speculations regarding possible causes of mental disorder, possible diagnoses or prognoses and possible treatments which he considers inadequately developed, confirmed or verified to warrant recording in the

client's regular mental health records. No authorization to disclose confidential information shall be effective with respect to such personal notes of a psychotherapist except an authorization to disclose the same to a physician or psychotherapist who occupies a professional relationship with the client whereby he is responsible for the treatment of the client and bound to observe confidentiality in that relationship. Upon receipt of such personal notes by such physician or psychotherapist, they shall be deemed to be his personal notes except to the extent that he transfers information from such notes to regular mental health records pertaining to the client.

(b) The keeping of such personal notes shall not relieve a psychotherapist from any obligation to record and maintain information pertaining to such matters as diagnosis, treatment, progress and all other information required in an individualized treatment plan as described in [sections \_\_\_ of \_\_\_]. \*/

COMMENT:

This optional provision is addressed to the problems of the dissemination of particularly sensitive and speculative types of confidential information and the consequent access which clients would have to such information (see section supra). This section would provide a relief valve for psychotherapists to record items of information which they might otherwise trust to memory rather than risk its disclosure to insurers, employers, the client or his guardian or parents. Some such information would, however, be valuable to record as an aid to his memory or for the use of a possible future therapist. This section would facilitate a totally protected recording of the information for such purposes.

How effectively or helpfully such a provision would be implemented is a speculative matter. Subsection (b) is intended to help prevent it from becoming an enormous loophole through which all valuable information would flow and thus leave the ordinary records less than fully useful.

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\*/ Provisions regarding individual treatment plans in sections on Mental Health Standards and Human Rights and Civil Commitment.



- G. Excerpt from Nathan, The Scope of Confidentiality Issues In the Modern Medical Setting (1970), at 23-35.

IV. The Patient and Non-Litigant's Right to Medical Records

1. Introduction

The prevailing view of area administrators and record room personnel can be summarized as: "We will make an individual's record available upon our determination that it is in his 'best interests.' We can think of no apparent reason or situation in which a hospitalized patient would want or be allowed access to his record."

This section will deal with the problems inherent in such medical views. A highly revealing study of such attitudes is presented as further introductory material. It is followed by a general discussion of these issues as well as a brief legal analysis.

2. The medical, ethical and legal views of medical personnel towards medical records have been tested in a number of empirical surveys. In one survey,<sup>45</sup> each hypothetical was pre-tested at a seminar of medical personnel in both the schools of Law and Medicine of U.C.L.A. After these preliminary tests, each hypothetical was submitted by questionnaire to one hundred doctors in California and one hundred doctors in Minnesota. Three of the posed hypotheticals are particularly revealing.

a) In the first, a recently discharged patient was attempting to obtain records to determine the identity of a doctor who negligently treated him. While the hypothetical involves a record possibly related to litigation, it was used to give an "interesting context" to the non-litigant patient's right to records.<sup>46</sup>

"P was a patient at a hospital and was injured due to the suspected negligence of one of the doctors. P does

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45. 14 J. of Forensic Science, p. 354 (1969).

46. Ibid at 356.

not know the identity of the doctor and seeks to look at his medical records at the hospital to see if they provide any clues. The hospital refuses to let P see his records."

Question: "Is the hospital justified in withholding the records?"

	Preliminary Questionnaire		Minnesota		California		Total	
	"Yes"	"No"	"Yes"	"No"	"Yes"	"No"	"Yes"	"No"
a) "medically?"	16	18	45	14	37	13	98	45
b) "ethically?"	15	21	42	15	33	17	90	53
c) "legally?"	13	19	34	17	29	18	76	54

Of the respondents, more than 2/3 thought there was no medical obligation to allow the patient to look at his records and a large majority thought that it was not required legally. The more frequent responses (and numbers) were as follows:

1. attorney or physician should ask because of danger of misinterpretation of records -- 9
2. subpoena necessary -- 11
3. patient should be told identity of doctors but not given records to look at -- 4
4. depends on how strongly negligence indicated -- 5

b) In the second hypothetical, the patient asked his previous doctor to send copies of records to his new doctor.

"P is treated by Dr. D for a broken arm. An X-ray was taken by the doctor, P paid for it, and the negatives are now in Dr. D's possession. P subsequently decides to go to another doctor and requests that the negatives or copies of them be sent to his new physician. P offers to pay for the cost of making copies. D refuses to deliver the negatives or copies."

Question: "Should Dr. D be required to deliver the negatives or copies of them to P's new doctor?"

	Preliminary Questionnaire		Minnesota		California		Total	
	"Yes"	"No"	"Yes"	"No"	"Yes"	"No"	"Yes"	"No"
a) "medically?"	23	14	53	10	50	3	126	27
b) "ethically?"	26	11	54	9	49	4	129	24
c) "legally?"	14	15	37	23	37	15	88	53

Surprisingly the authors indicate that there were no "meaningful" comments to the hypothetical that would explain the relatively large number of "no" answers, although the respondents did overwhelmingly indicate that the records should be sent as a medical and ethical matter, though a smaller majority indicated that it was also necessary legally. There is no doubt, at least ethically and legally that the record should be delivered to the new physician.<sup>47</sup>

c) The third hypothetical concerned a patient who wanted a copy of his record for no particular reason and it was clear that he would not be harmed in a medical sense by receiving it.

"A patient has a hernia operation. He is a bright, mentally balanced individual. The operation is a complete success. He comes to the doctor and asks for a photocopy of his medical record. He offers to pay."

Question: "Would withholding the copy be proper?"

	Preliminary Questionnaire		Minnesota		California		Total	
	"Yes"	"No"	"Yes"	"No"	"Yes"	"No"	"Yes"	"No"
a) "medically?"	21	1	39	18	29	22	89	41
b) "ethically?"	23	0	38	20	30	21	91	41
c) "legally?"	16	3	35	18	24	23	75	44

The more frequent comments and the number of commentators were as follows:

1. record only given to another doctor or insurance company -- 11
2. patient should get summary but not actual record -- 5

47. See infra at notes 55-63.

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A large majority of the seminar participants and a smaller majority of the questionnaire respondents thought the doctor was not obliged to furnish the record. As would be expected, the formal statement of medical ethics of the American Medical Association is in accord with the view that patients are not entitled to information from medical records:

The Judicial Council does not believe that medical ethics intends or requires that a physician give a copy of his records to his patient.<sup>48</sup>

3. The reasons stated by the California and Minnesota doctors as well as area physicians for denying the patient or non-litigant access to his records are not particularly persuasive. They include:

a) It is a time consuming process to make records available upon request, i.e. to the medical staff and record room personnel.

b) The patient may notice that the record is incomplete, inaccurate or contains uncomplimentary remarks, all of which may result in embarrassment to the institution.<sup>49</sup>

c) Making records available will result in an increase in malpractice suits.

d) The patient has no "right" to the record. It is merely a means of communication among medical personnel.

e) It is hospital policy. The record is the property of the hospital and in a case where the patient desires to examine the record the matter should be referred to the physician or Administrator.<sup>50</sup>

Initially, it can be stated that while some staff time ( a) above) will be involved in finding a record, the actual time involved will be minimal since open patient access to records is

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48. American Medical Association, Judicial Council Opinions and Reports, p. 57 (1967).

49. The trade "in-joke" concerns the proverbial seventy-year-old spinster who saw the notation "patient -- S.O.B." on her chart. She was persuaded to drop her defamation action when informed that the phrase stood for: "patient short of breath."

50. Compiled from area interviews.



not likely to lead to wholesale requests. As arguments can be made that a physician should examine the record prior to its release (best interest theory), this still does not necessarily mean that this will place a heavy burden on the resources of the profession. While particular patients may be shocked and dismayed by the incompleteness and inaccuracy in their records ( b) above), this is certainly not a sufficient reason for complete denial of access. Patient access may make it more, rather than less likely that records will be better kept. Fear that the record may spark a lawsuit ( c) above) is not a justifiable reason for denying access; in fact denial of access to a medical record often raises suspicions that do lead to malpractice suits.<sup>51</sup> That reasons d) and e) (above) are unsound will be evident after an examination of the legal issues involved.

In a number of jurisdictions the determination of a "right" to access can be made by reference to either common law or statute.<sup>52</sup> In those jurisdictions where recourse to common law

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51. See text accompanying notes 32-33.

52. Conn. Gen. Stat. Annot. 4-105. Procedure where right to inspect records is denied

If any patient who has received treatment in any such hospital, after his discharge from such hospital, has made written application to such hospital, hospital society or corporation for permission to examine his record as such patient in such hospital and has been refused permission to examine or copy the same, such patient may file a written motion addressed to any judge of the superior court, praying for a disclosure of the contents of such hospital record relating to such patient and for a production of the same before such judge. Upon such application being filed, the judge to whom the same has been presented shall cause reasonable notice to be given to such hospital, hospital society or corporation of the time when and place where such petition will be heard, and such judge, after due hearing and notice, may order the officer authorized to act in the capacity of manager of such hospital to produce before him and deliver into his custody the history, beside (sic.) notes, charts, pictures and plates of such patient for the purpose of being examined or copied by such patient, his physician or authorized attorney. Each officer of any hospital having custody of the history, bedside notes, charts, pictures or plates of any patient therein, who refuses to produce such record before such judge, pursuant to the provisions of this section, shall be fined not more than one hundred dollars or

(Fn. 52 continued on next pg.)

or statute is unavailable, the "right" could be established by analogy to other areas of the law.

For example, a patient or non-litigant attempting to secure his records might point out that the statutes of a number of jurisdictions require hospitals to keep records<sup>53</sup> and that they should be kept confidential.<sup>54</sup> Further, there are statutes in various jurisdictions which state that the patient "owns" the information in the record to the limited extent that the physician-patient privilege gives the patient control over the use in court of information "transmitted between the patient and his physician."<sup>55</sup> In addition:

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(Fn. continued from prev. pg.) imprisoned not more than six months or both.

Note that this section refers solely to discharged patients. See also Cal. E. Code § 1158.

53. Pa. Stat. Ann. tit. 35 § 450305. Registration districts: institutional records required

All superintendents, managers and other persons in charge of hospitals, maternity homes, homes for the aged and public and private institutions to which persons resort for medical care or to which persons are committed by process of law, shall obtain and record as to each inmate, at the time of his admittance, all personal information required in the certificates prescribed by the department. Each inmate shall supply such information at the time of admittance, but if the inmate is unable personally to supply the information a relative of the inmate or other person acquainted with the facts shall do so. 1953, June 29, P.L. 304, art. III, § 305.

54. Pa. Stat. Ann. tit. 35 § 45801. Records: disclosure in general

The vital statistics records of the department and of local registrars shall not be open to public inspection except as authorized by the provisions of this act and the regulations of the Advisory Health Board. Neither the department nor local registrars shall issue copies of or disclose any vital statistics record or part thereof created under the provisions of this or prior acts except in compliance with the provisions of this act and the regulations of the Advisory Health Board. 1953, June 29, P.L. 304, art. VIII, § 801.

55. Cal. Ev. C. § 92.

"Whenever prior to filing of any action, an attorney ... presents a written authorization therefore, signed by a patient [records] shall be made available for inspection and copying by such attorney."<sup>56</sup>

These statutes speak to an obvious state interest in proper hospital record management and their use in and availability in lawsuits. However, they do not really speak to the point of a non-litigant's right to inspect and copy his own records.

Case law of various jurisdictions indicate that a patient is entitled to the information kept by a hospital. Although the physical records, i.e. the paper, the negatives are the property of the hospital,<sup>57</sup> the patient does have a proprietary interest in the records themselves, which allows him to inspect or obtain a copy.<sup>58</sup> The above statement based [on] only a limited number of decisions is further limited by various judicially imposed limitations. Thus, if it is not in the "best interests" of the patient's health to release the information, the doctor or hospital could be justified in withholding it.<sup>59</sup> This presents, once again, the problem of what constitutes and who determines what such "best interest" in fact is: A hospital administrator? A physician? A lay advocate? The patient? Some jurisdictions require a "clear case" before denial would be proper;<sup>60</sup> others would give the record holder much greater discretion.<sup>61</sup> Withholding the record while the patient was either hospitalized or under treatment would probably be justified although there is no case law on that specific point. Other legal points can be summarized as follows: next of kin have a "right" to information

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56. Ibid.

57. Wallace v. University Hospitals of Cleveland, 164 N.E.2d 917 (1959); Pyramid Life Ins. Co. v. Masonic Hosp. Ass'n. of Payne Co., 191 F.Supp. 151 (1961).

58. Bishop Clarkson Memorial Hospital v. Reserve Life Ins. Co., 350 F.2d 1006 (8th Cir. 1965); Abelson's Inc. v. New Jersey State Board of Optometrists, 65 A.2d 644 (1949).

59. In re Culbertson's Will, 57 Misc.2d 391, 292 N.Y.S.2d 806 (1968).

60. Bishop Clarkson Memorial Hospital v. Reserve Life Ins. Co., 350 F.2d 1006 (8th Cir. 1965).

61. Wallace v. University Hospitals of Cleveland, 164 N.E.2d 917 (1959).

from the record in the event the patient dies;<sup>62</sup> the patient if deemed entitled to inspect can authorize another, e.g. his insurance company to copy the record;<sup>63</sup> the latter, however, cannot inspect, despite an authorization, where it has already and unconditionally paid the patient's claim and therefore has no business reason to inspect the patient's record.<sup>64</sup>

4. While the common law "generally" favors disclosure (i.e. upon discharge), unless clearly adverse to the patient's best interest, federal government regulations on the matter are apparently less favorable to the patient. The Veterans Administration policy is typical. The veteran is limited to information concerning himself alone<sup>65</sup> and, in fact, he may be unable to get even those records if the disclosure would either: a) reveal a confidential source or b) if he does not indicate a "purpose," i.e. if the patient wants the record, just because he wants it, he may not receive it.<sup>66</sup> Another provision, which overrides general availability sections, strongly suggests that the information may not be released unless it serves a "useful" purpose.<sup>67</sup> Thus, it is once again a question of the hospital unilaterally determining what those "useful purposes" and "best interests" in fact, are.

The regulations of the Public Health Service make no qualms over their discretionary power and clearly indicate that the patient must show a "need" for the records.<sup>68</sup> He may not receive his records although obtaining them would not be contrary to his best interests.

Upon a reasonable showing of the need therefor, the officer in charge of a hospital ... may authorize disclosure to a patient ... of such clinical information as such officer determines to be medically appropriate for disclosure .... If

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62. Emmett v. Eastern Dispensary and Cos Hospital, 396 F.2d 931 (D.C. Cir. 1967).

63. Pyramid Life Insurance Co. v. Masonic Hosp. Assn. of Payne Co., 350 F.2d 1006 (8th Cir. 1965).

64. Pyramid Life Insurance Co. v. Gleason Hospital, Inc., 188 Kan. 95, 360 P.2d 858 (1961).

65. 38 C.F.R. § 1.525(a)(3).

66. 38 C.F.R. § 1.526(a).

67. 38 C.F.R. § 1.501(a).

68. 42 C.F.R. § 1.101 - 1.108.



the patient's examination, treatment or care was requested or arranged for by a governmental agency, the information shall not in any event be disclosed without the consent of that agency.<sup>69</sup>

Records may be "released" temporarily for purposes of examining or copying them,<sup>70</sup> but "under no circumstances should the person inspecting the records be permitted to handle or inspect them without a representative of the Public Health Service being present in the room."<sup>71</sup> The latter provision is an adequate example of agency paranoia in these matters.

The belief that denial of access is a "self-help" technique in defending malpractice suits is an important factor in the medical profession's continued refusal to make certain records available. Evidently, the profession does not accept the obvious proposition that except for privileged information, a medical record which contains evidence relevant to a lawsuit can almost always be obtained in all jurisdictions. Specifically, recently enacted statutes make this fact even clearer.<sup>72</sup> Thus, to deny a patient access to his records on the belief that he will thereby be frustrated in bringing a lawsuit is a mistake. Ultimately, the ex-patient will get his record. Some in the medical profession are dimly beginning to recognize the inadvisability of a policy of denying patients access to their records. For example, the policy of the American College of Radiology suggests that a liberal attitude regarding the release of films is more desirable than strict insistence on the right to require a court order before producing them.<sup>73</sup> Nevertheless, such negative attitudes persist across the spectrum -- especially in the situation where the patient is attempting to determine who the negligent doctor, in fact, was. The only legal justifications in such a situation for withholding records are that a) the hospital might not have the sole right to the records and perhaps is indeed obligated to inform the specific physician(s) involved before making the

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69. 42 C.F.R. § 1.102(b)(1).

70. 42 C.F.R. § 1.107(a).

71. Bernsweig, Legal Aspects of Public Health Service Medical Care, p. 63 (1966).

72. Cal. Ev. C. § 1158; Cal. Welf. & Inst. C. § 5328(f); Conn. Gen. Stat. Annot. 4-105.

73. Quoted in Hayt and Hayt, Legal Aspects of Medical Records, pp. 60-62 (1966).

disclosure and b) the hospital is obligated to check with the physician to determine whether it could, in fact, cause "medical harm."

Regarding the second hypothetical (doctor to doctor transfer) there is no disagreement between the medical profession and the law. However, this is not the case where (as in the third hypothetical) a patient wants his record for some unexpressed purpose and it would do no medical harm. Such access is discouraged and threat of court action is often the only answer -- albeit usually satisfactory in eventual outcome. However, the morality of forcing such action is questionable at best and is akin to forcing the hospital to sue on an overdue legitimately incurred medical bill.

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## MEDICINE AND THE LAW

### OPINIONS OF JUDICIAL COUNCIL

*The Judicial Council has authorized the publication of the following opinion. This and other opinions approved by the Judicial Council will be published in "Medicine and the Law" and will be added, as a supplement, to "Opinions and Reports of the Judicial Council."*

**Question:** A "fee complaint" committee of a county medical society has asked whether the second sentence of section 7 of the Principles of Medical Ethics specifically authorizes a physician to double his fee if the patient's income is twice that of the average person or whether it means that when a patient's income is less than average the fee should be reduced.

**Opinion:** The Principles of Medical Ethics are "standards by which a physician may determine the propriety of his conduct." They are guides to be observed, not laws to be enforced. The second sentence of section 7, providing that a physician's "fee should be commensurate with the services rendered and the patient's ability to pay" is such a guide. It is a general principle which should aid the physician in considering his fee. In addition to legal prohibitions, the very nature of medical practice prevents the rigid establishment of inflexible fees for the many services which may be rendered to any individual. This principle does not suggest, therefore, that a physician set his fee with mathematical accuracy nor does it impose on him an obligation to act contrary to conscience, reason, or experience.

In the opinion of the Council, "commensurate with the services rendered" recognizes that although there are some services which are considered invaluable, nonetheless their practical value lies within a range,—within limits above or below which a fee is unconscionable. In the opinion of the Council a "patient's ability to pay" is a secondary factor, one to be considered after, not before, value "commensurate with the services rendered" is ascertained. In the further opinion of the Council it is not contrary to conscience for the physician to consider the patient's ability to pay if he fixes his particular fee within reasonable limits. The language used in this section is intended only to suggest that a physician try, in matters relating to fees, to the best of his ability to insure justice to the patient and himself and respect for his profession.

In the opinion of the Council, this section cannot properly be interpreted to mean that a physician or a group of physicians must fix average fees

to be increased or reduced according to the patient's economic status, nor to imply that an arbitrary sliding scale of fees is to be adopted and applied individually or by the profession. It may not be used to justify an excessively high fee or to approve an inadequately low fee.

The Council feels this subject is important enough to add the comment that the physician can obviate many fee-complaints (and consequent ill-will) by discussing fees with his patient so that the patient may understand and appreciate the value of the service for which the fee is paid.

### OWNERSHIP OF AND ACCESS TO HOSPITAL RECORDS

Considerable uncertainty exists concerning the right of access to hospital records. Physicians, patients, hospital staff personnel, and others are not clear as to their respective rights and obligations. This uncertainty may result from the fact that there is a lack of knowledge generally about what constitutes the "hospital record" and from the fact that there is no well defined body of law relating exclusively to hospital records—insofar as either their maintenance or their use is concerned.

#### What Is the Hospital Record?

Patients and their representatives compound the confusion because they do not know that hospital records relating to a single patient include an administrative record and a clinical record and may also include a social record. For present purposes the term "hospital record" will be used to mean only the patient's clinical record. Few persons, other than physicians and hospital personnel, know that the patient's clinical record consists of data recorded on at least 12 different forms. Each form contains data relating to the patient's medical or surgical care and treatment when he was hospitalized. Consequently, the patient who speaks of his hospital record or who authorizes his attorney or insurance adjuster to inspect his hospital record seldom realizes that this record is a collection of records.

In 1952 the American Hospital Association assembled thirteen model record forms and distributed them, with brief comments concerning their use. They have been widely accepted. These forms include (1) summary, (2) history, (3) physical examination, (4) progress notes, (5) physician's orders, (6) clinical laboratory reports, (7) x-ray reports, (8) consultation reports, (9) anesthesia record, (10) operation record, (11) graphic record,

(12) nurse's notes, and (13)—in appropriate cases—a labor record. In the case of short-stay patients (48 hours or less) a short-stay record form is used which includes the diagnosis, the results of the physical examination, and reports of laboratory tests necessary for proper evaluation of the case. Accident cases require the completion of a report of accident form.

Rules and regulation of the hospital and requirements of the Joint Commission on Accreditation of Hospitals demand that these records be authenticated. The joint commission requires that the attending physician sign the summary, the history, physical examination, physician's orders, progress notes, and reports of operations on all patients.

These forms—this hospital record—represent the who, what, why, where, when, and how of patient care in the hospital. The primary purpose of these forms is to make available at all times a complete, up-to-the-minute written record of the patient's condition and treatment.

#### Must a Hospital Maintain These Records?

Obviously with the complexity of modern medical and surgical care necessity exists, within the hospital, for making and keeping (1) records of diagnosis and the steps taken to verify it and (2) a record of treatment and the steps incident to giving it. Good judgment and common sense, efficiency and good business practice, in the absence of any statute, dictate the necessity for keeping a written record of the facts and the observations, orders, prescriptions, reports, and interdepartmental and interprofessional communications made during each patient's hospital stay.

Some public or governmental hospitals are required by statute to keep "records" but these statutory provisions are in the interest of governmental administration and not particularly for the benefit of the hospital, patient, or physician.<sup>1</sup> By and large, statutes are silent concerning "hospital records." The exact nature and extent of records which must be kept by hospitals have not been the subject of statutory definition. Technically, according to law, the clinical records of a hospitalized patient could be maintained by the doctor attending the case according to his own wishes and preferences much as he maintains records for nonhospital cases. For the sake of uniformity and completeness, however, standardization by hospitals of the form of the hospital patient's clinical record has become an accepted regimentation.

It seems clear that the keeping of records is an incident of efficient operation of the hospital. Examination of the several forms will confirm this view. Provisional diagnosis, for example, made known to the hospital on or before the patient's admission and later entered on the summary form, facilitates the assignment of a patient to the proper service and alerts the hospital staff to the patient's

possible need for special therapy. The Joint Commission on Accreditation of Hospitals urges that the hospital be furnished with a provisional diagnosis, to be entered on the summary form, at or before admission. The physician's orders form indicates his orders and prescriptions and reduces the risk of misunderstanding and forgetfulness. Request for and report of consultation pinpoints facts and opinions in relation to a particular patient and his particular condition. Progress notes reflect the patient's response to or failure of particular therapy. Thus a collection of many facts in an orderly manner in one place and for one person enables the doctor to "keep on top" of each case he treats within the hospital. Additionally, they can be of inestimable value to any other physician who may be called upon to aid or replace the original attending physician.

In considering, then, the question of access to hospital records, as the term is used herein, it must be borne in mind that (1) the record is a collection of clinical data and (2) the record is maintained as a hospital discipline. The records executed by physicians are required as a condition of staff membership by hospital rules or regulations. They should be treated as such from the legal point of view, that is, they are the business record of the hospital and the physical property of the hospital. Like an x-ray plate or a photographic negative, which belong to him who is to furnish a report or a service, the record is not an item of contractual consideration when hospital stay is considered and arranged. It may be noted, in passing, that the American Medical Association through its House of Delegates expressed the following policy, with respect to another type of hospital record (staff minutes), in December, 1957: "The responsibilities of the governing board of a hospital does (sic) not abrogate the moral and legal responsibility of a physician for the medical care which he renders to his patient in the hospital."

When a person is hospitalized there is no implied agreement that the hospital will maintain for and deliver to him, at his request, any one or more of the numerous forms that make up his "hospital record." A recent article<sup>2</sup> on access to hospital records makes a very logical case for revising the hospital admission form to include a release permitting use of these records. At best, under ordinary circumstances, it would seem that the hospital should have no obligation, legal or otherwise, to surrender possession of the patient's record. Ownership of the patient's record lies in the hospital.

#### Purpose and Historical Value of Record

The several forms which comprise the clinical record of the patient while hospitalized are filled in by the attending physician (or an intern or resident acting under his direction and supervision), consultants, and nurses. The attending physician



makes principal use of the record. Nurses and consultants also refer to and use the record in carrying out their duties in relation to the patient. And when the patient is discharged from the hospital it is the attending physician who completes the summary form and writes *finis* to that particular record. From that point on, the record is principally of historical value. Its chief purpose has been accomplished. The record is preserved by the hospital for the benefit of the patient, for its own use, for the use of the attending physician or his successor, and for scientific research purposes.

It may be of value to the patient (1) in treating future illness or during later hospitalization, (2) to eliminate the necessity for repeating procedures already performed, (3) to aid in recovery of insurance or other benefits to which the patient or his representatives are entitled, and (4) to establish a failure to provide the requisite degree of skill and care to which, in the circumstances, the patient was entitled.<sup>3</sup>

For hospital purposes, administrative analysis of the record as an impersonal document is considered necessary. The hospital conducts such an analysis as it continually strives to improve its services, as it reviews the past and plans for the future. Too, the record is of importance to the hospital in defending itself against a charge that (1) it may have been negligent in its duties to the patient during the period of hospitalization or (2) it did not exercise proper care in the selection or retention of its employees.

A physician may find the hospital records to be of value as he refreshes his recollection of the patient's history and treatment when he is subsequently called upon to treat the patient. He may find in the record, as an impersonal document, material for scientific research or for articles for the benefit of the medical profession. And he may find in the record evidence that will support a defense against a charge brought against him that he was negligent in his care of his patient.

#### Right to Inspect Hospital Records

Must a hospital furnish an abstract of its records or permit a former patient, or his duly authorized representative, to inspect the records of that patient's case?

From the legal point of view these records may be subpoenaed. Whether or not they will be admitted is a matter that depends on the law of the particular jurisdiction. In general, in the absence of objection on the part of the patient, who may properly invoke the doctrine of privilege in certain jurisdictions, they are held admissible. When the patient himself seeks to introduce these records they are generally held admissible over the objection that they are hearsay evidence. An excellent discussion of the admissibility of hospital records

was written by Harold Levine, a member of the Chicago Bar, and published in the February, 1957, issue of *The Trial Lawyers Guide*. No summary can do the article justice. It should be read in its entirety.

The more important legal uncertainties relate to the right of inspection in the absence of litigation; that is, when the patient wishes to inspect his record to satisfy his personal curiosity, or to comply with requirements of an insurance contract or a compensation program. Must the hospital furnish all or part of the record to such a patient on request? May, or must, the hospital honor the request of the patient to furnish all or part of the record to an investigator, adjuster, or attorney? Is it necessary for the hospital to have permission from the attending physician before it discloses information contained in the medical records? May a hospital permit other physicians to review the records without the patient's consent and without the consent of the attending physician?

It is generally agreed that since the physical ownership is in the hospital, and since the subject matter of the records relates to a definite, identifiable human being, consent or authorization for the use of the records must come from these two sources. The hospital and the patient must consent to the use of the records by some other party when those records are used as a personal document. When anonymity is preserved and the records are used as an impersonal document in medical or other scientific research, it is to be doubted that the consent of the patient is needed. Because the records belong to the hospital and are kept as a hospital discipline, it is doubted that consent to their use by the attending physician is necessary, especially after the record is completed and the patient is discharged from the hospital. The physician does not own them and usually prepares them at the direction of the hospital or pursuant to its regulation rather than of his own volition for his personal use and keeping. Thus, affirmatively, there should be no legal problem if the patient and the hospital consent to the use, inspection, or review of the records.

If the patient wishes the record and the hospital refuses to permit access to it, might the patient successfully maintain an action at law to compel the hospital to accede to his request? In a California case,<sup>4</sup> the District Court of Appeals said, "The doctor-patient relationship is a fiduciary one and it is incumbent on the doctor to reveal all pertinent information to his patient. The same is true of the hospital-patient relationship. In the event of the death of a patient while under the care of the doctor and the hospital the spouse has a right to know the cause of death. Withholding information would in a sense be a misrepresentation." In another California case,<sup>5</sup> before the Supreme Court of the state,

where the question concerned the running of the statute of limitations when there was concealment of a medical failure, it was said the confidences growing out of the relationship between doctor and patient imposed on the physician the duty of refraining from fraudulent concealment, that is, the duty of disclosure when he had knowledge of the facts. Where there is a duty to disclose, the disclosure must be full and complete and any material concealment or misrepresentation will amount to fraud sufficient to entitle the party injured thereby to action.

It does not follow from these references that in any or in all jurisdictions a court would order a hospital to disclose information in its records in the absence of a showing that there was good reason for patient's request.

#### Statutes and Court Decisions

A number of states have hospital lien laws.\* These laws permit the hospital to file a lien to cover the cost of such items as service, food, lodging, and supplies, reasonably necessary for the treatment, care, and maintenance of a patient hospitalized for "an injury suffered through the fault or neglect of some one other than the patient himself" or for "personal injuries received in any accident" for which the injured person claims damages or compensation, or the like. The lien—filed with the clerk of some specified court, served on the patient, or mailed to the person or corporation alleged to be liable—becomes a claim against any award, judgment, or final order of any court or public board or any settlement or compromise accruing from a claim asserted or maintained by the patient.

Some of the lien laws provide that "any party to a cause pending in a court of record against whom a claim shall be asserted for damages resulting from said injuries shall, upon request in writing, be permitted to examine the records of such hospital in reference to such treatment care and maintenance of such injured person."

Obviously the statutes, creating liens in favor of hospitals, must be studied and their own particular provisions ascertained before it can be said they give any right to access to or inspection of hospital records. Further, it must be recognized that these statutes apply only to specifically defined situations and are not authority for indiscriminate inspection of hospital records.

In *Application of Larchmont Cables, Inc.*,<sup>7</sup> where an insurance company had been refused the right to examine the hospital record, the company moved to discharge the lien. The court held that "although the language of the statute is particularly broad it is not reasonable to determine that it was intended to require a hospital to reveal confidential information—nor was it necessary in order to determine the

reasonableness of the hospital's charges to examine records as to the diagnosis of the ailment or disease of the patient. The hospital should comply with the statutory requirement and furnish all information possible in respect to the treatment, care and maintenance of the injured person without disclosure of confidential communications."

Another case<sup>8</sup> in New York related to testamentary competency of a woman who, afflicted with mental disability, had been confined to a state mental hospital shortly after executing a will. Objection was made to the probate of her will on the ground that she lacked testamentary capacity. A special guardian, duly appointed, made application under the provisions of another New York statute to inspect the hospital records. The court said that, an issue having been created as to the competency of the testatrix, it would seem that information bearing on that issue should not be kept from the contestants or the court and that the special guardian should be afforded an opportunity to make a fair and full inquiry concerning the mental capacity of the testatrix.

In *De Nardo vs. De Nardo*,<sup>9</sup> an application was made by the brother of a husband to annul the marriage on the ground of mental incompetency at the time of marriage. The court granted the application for a subpoena duces tecum with respect to the production of hospital records concerning treatment, reports, and case records of the incompetent stating that "evidence of the wife's knowledge and action on that knowledge in marrying an incompetent should not be concealed."

In *Kinbacher vs. Schneider*,<sup>10</sup> an action to set aside a deed to real property, a motion was made for an order requiring the director of a state hospital to produce, for the purpose of inspection, all records pertaining to the admission and diagnosis of the condition of the deceased, who four days before his admission to the hospital as a mentally ill person executed a deed to the defendant. The court denied the motion on the ground that no personal representative of the deceased had been appointed by law and that the defendant did not comply with the language of the statute as one who is entitled to inspect the hospital records.

#### Confidential Communications and Right of Privacy

The question of privilege, with respect to the clinical records of a hospitalized patient, is not considered here, except to point out that if the privilege does exist it is for the patient's benefit and must be claimed by him. It is neither for the doctor's nor the hospital's benefit and it may not be claimed by them.

If a person, a hospital, or a doctor discloses some information about a patient or another person that is confidential and should not be disclosed to the public, the trend seems to be to bring an action for

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a violation of the right of privacy. This theory of law has developed within the past 75 years or less and is a tort action based on one's right, if acknowledged within a particular jurisdiction, "to be let alone." Among the cases on this subject are several which are of interest in connection with hospitals and hospital records.

In *Barber vs. Time, Inc.*<sup>11</sup> a national magazine described the patient's affliction and in connection with the story published a photograph of the patient in bed in hospital attire. The patient sued and was awarded \$1,500 actual and \$1,500 punitive damages although the latter was set aside because of lack of a showing of malice. The Missouri Supreme Court said that if there is any right of privacy at all it should include the right to obtain medical treatment at home or in a hospital for an individual personal condition (at least if it is not contagious or dangerous to others) without publicity.

A more interesting case arose in Pennsylvania.<sup>12</sup> The plaintiff was being treated for a coronary thrombosis. Her physician took pictures of her facial expressions while she was unconscious in the hospital without her consent, allegedly for the purpose of graphically recording an effect of the illness. Suit was brought for return of the film and whatever prints had been made therefrom. The right to maintain the action was sustained. The court said, "While the court appreciates the development of the art of photography generally, and in the medical profession particularly, not only as a means of diagnosis and treatment but as a means of instruction, its progress has not as yet reached the stage that our physicians have been accorded the right to photograph their patients without their consent nor has medical jurisprudence recognized the unlimited right of a physician to perform any test, administer any treatment, or perform any operation without the consent of the patient." A New York case<sup>13</sup> discusses the publication of a scientific article in a state medical journal.

*Bazemore v. Savannah Hospital*<sup>14</sup> is also of interest in this connection. In that case a tort action in the nature of trespass on the rights of privacy of the parents of a child was brought against a hospital, a photographer, and a newspaper. The facts were that a child had been born with its heart on the outside of its body. The family physician took the child to the hospital, where a photographer was permitted by the hospital to take photographs of the nude body of the deceased infant. Facts concerning the case and the photographs were given to a newspaper, which published the story and picture. The hospital entered a general demurrer to the petition of the parents (admitting for that purpose the truth of the allegations but denying that the child's parents had any cause of action against the hospital). The trial court sustained the position of the hospital, but the Supreme

Court of the state reversed the trial court's holding that the petition filed by the parents for general and special damages and for injunctive relief was cause of the alleged tortious act and set forth a cause of action against the hospital.

### Conclusions

There is no general understanding or appreciation outside medical and hospital groups of the nature, extent, purpose, and use of hospital clinical records. Lack of knowledge by patients and their representatives and the failure of hospitals to devise a summary form containing information to meet a patient's needs, which may be furnished on request, compounds this confusion.

Ownership of hospital clinical records lies in the hospital. Primarily it is the right and obligation of the hospital to grant authorization to inspect and use these records. To the extent that these records are treated as personal documents a patient also possesses a concomitant right to grant authorization to inspect and use the records. Between the patient and the hospital, it is the legal right of the hospital to grant authorization to inspect and use these records. The consent of the attending physician is unnecessary legally but may be obtained as a professional courtesy.

Statutes and court decisions concerning the use or right to inspect hospital clinical records are not numerous. In their absence or to supplement them where they do exist hospitals may provide, and should promulgate, reasonable rules concerning the use of and right to inspect the clinical records of patients. Litigation should not be necessary to clarify the status of the right of access to hospital clinical records.

### References

1. *Sovereign Camp of Woodmen of the World v. Grandon*, 89 N. W. 448 (Neb., 1902) and, for example, the Mental Hygiene Law of the State of New York.
2. Ludlam, J. E. and McCabe, T. A. Jr.: *Disclosure of Medical Record Information: Reappraisal*; Part 2, Hospitals 31:56-61 (Aug. 1, pt. 1) 1957.
3. *In the Matter of Weiss*, 147 N. Y. S. (2) 455 (N. Y., 1955).
4. *Wohlgemuth v. Meyers, et al.* 293 P. (2) 816 (Cal., 1956).
5. *Stafford v. Shultz*, 270 P. (2) 1, (Cal., 1954).
6. Among others may be mentioned Arkansas, Delaware, Indiana, Illinois, Iowa, Kansas, Maryland, Minnesota, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Oregon, Rhode Island, Texas, Virginia, and Washington.
7. 64 N. Y. S. (2) 623, (N. Y., 1946).
8. *In re Grabau's Will*, 85 N. Y. S. (2) 748 (N. Y., 1948).
9. 66 N. Y. S. (2) 123 (N. Y., 1944).
10. 89 N. Y. S. (2) 350 (N. Y., 1949).
11. *Barber v. Time, Inc.*, 159 S. W. (2) 291 (Mo., 1942).
12. *Clayman v. Bernstein*, 30 Pa. D. & C. 543 (Pa., 1940).
13. *Griffin v. Medical Society of State of New York*, 11 N. Y. S. (2) 109 (N. Y., 1939).
14. 155 S. E. 194 (Ga., 1930).

### **Program to Examine Appellate Caseloads**

A national conference has been scheduled for next month to examine methods for dealing with what was described as the "staggering" growth in the number of cases reaching the state and federal appeals courts throughout the country.

Professor Maurice Rosenberg, of Columbia Law School, chairman of the conference scheduled for Jan. 23-26 in San Diego, Calif., said about 250 judges, lawyers, government officials and educators are expected to attend. The conference will be co-sponsored by the National Center for State Courts and the Federal Judicial Center.

Among those scheduled to participate will be Judges Wilfred Feinberg and Henry J. Friendly of the Second U. S. Circuit Court of Appeals.

Professor Rosenberg said the conference will seek to "convert its best ideas into legislative reality."

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# Prediction of Dangerousness in Mentally Ill Criminals

David Rubin, MD, Chicago

Belief in the psychiatrist's ability to predict the likely dangerousness of a patient's future behavior is almost universally held, but lacks empirical support. This paper is an attempt to organize the problem of prediction of dangerousness. Recent empirical studies which begin to isolate the characteristics of danger as well as using data from the psychiatric, sociologic, and legal literature are cited. The histories of a group of mentally ill criminals released from prison which I have followed over time, are examined in terms of possible determinants of their dangerousness. Predictions are made and compared to those made by others. Conclusions are that social factors have primacy, while psychological factors require further study.

Treatment interventions depend on predictions of the likely consequences of such interventions. Such predictions are unavoidable for the psychiatrist, as indeed they are for anyone who proposes to treat another's illness. There is, however, another type of prediction, that of the likely dangerousness of a patient's future behavior. This prediction is expected of the psychiatrist—and psychiatrists acquiesce daily. This belief in the psychiatrist's ability to make such predictions is firmly held and completely relied upon, in spite of a lack of empirical support. The law requires, in Illinois as in other states, that the commitment of a mentally ill patient depend on psychiatric testimony. The patient must be in need of mental treatment and dangerous to himself or others.

Similarly, relevant commitment and release laws concerning psychologically disturbed criminals accused or convicted of a serious crime, depend upon psychiatric testimony as to the likely recurrence of serious crime.

The problem is not a small one. Although the number of commitments to mental hospitals have been steadily reduced in the past ten years approximately 10,000 mentally ill persons per year are predicted to be dangerous and preventively detained for society's and protection as well as their treatment. In addition 5% (2% to 28%) of the total mental hospital population of the United States (approximately 337,000) are in maximum security sections on assessment of their criminal dangerousness. Of the approximately 600,000 to 598,660 persons who will be apprehended and accused of index crimes against persons (homicide, aggravated assault, forcible rape, and robbery) in a year, about

5% to 10% will be examined (pretrial or presentence) to advise the court about their potential future dangerousness and associated questions of appropriate intervention (prison vs hospital, etc). Lastly about 10,000 persons designated as mentally ill offenders will be admitted in a year (1967—11,840 admissions—estimate 10,000 persons), two thirds of whom will be in special hospitals for the criminally insane, one sixth in ordinary mental hospitals, and one sixth in correctional institutions. These include persons who are: (1) charged with a crime, and held pending determination of their competency to stand trial. (2) Charged with a crime and found incompetent to stand trial. (3) Found not guilty by reason of insanity. (4) Convicted of a crime and found mentally ill at the time of sentencing. (5) Found to be mentally ill while serving a sentence. (6) Sex offenders not included in the above. Of this group, those in the last five categories require yearly or more frequent examinations or reviews to determine whether the state of predicted dangerousness has altered, modified, or disappeared.<sup>1,2</sup> Szasz has compellingly written<sup>3</sup> that the behavioral sciences have not yet been able to solve simple and operational definitions of eccentricity and dangerousness, and because of that he feels<sup>4</sup> that psychiatrists have been motivated in large part to be counter-aggressive to very provocative patients. Such aggressiveness can be related to the psychiatrist's identification with prevailing societal sanctions regarding certain deviant behavior, to an unwillingness by the psychiatrist to share power, and to the psychiatrist's personal readiness to respond to provocative behavior. Szasz's answer is to reject the concept of dangerousness and to argue that the psychiatrist, in the conflict between the patient's and society's rights, should always side with the patient. As Szasz notes correctly<sup>5</sup> few people are dangerous and psychiatrists as a bearer of society's guilty decision to punish. But what about the "few" who are dangerous?

For some investigators concerned with prediction there is no serious problem. It matters only that the right diagnostic test be done to isolate a particular brain-damaged population at risk.<sup>6,7</sup> For others<sup>8,9</sup> certain toxins are implicated as the predictive cause of violent behavior. Subcultures are described<sup>10,11</sup> and those descriptive qualities are dealt with as predictive of violent behavior. Careful clinical study<sup>12,13</sup> is done and thought to provide sufficient data for prediction.

This naive certainty has not been supported by empirical studies nor by the few evaluations of the results of such prediction. Even in the most careful, painstaking, laborious, and lengthy clinical approach to the prediction of

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From the Department of Psychiatry, University of Chicago, Pritzker School of Medicine.

Reprint requests to the Department of Psychiatry, University of Chicago, Pritzker School of Medicine, 950 E 59th St, Chicago 60637 (Dr. Rubin).

dangerousness, false positives may be at a minimum of 60% to 70%."

In addition to the area of civil commitment, Morris and Hawkins," note that the American Law Institute's Model Penal Code provides that criminal sentence may be extended if the person is a "dangerous mentally abnormal person," and in the Model Sentencing Act of the Advisory Council of Judges of the National Council on Crime and Delinquency, dangerous offenders are defined as those who have committed or attempted certain crimes of physical violence and who are found to be "suffering from a severe personality disorder indicating a propensity toward criminal activity." The Durham decision in the District of Columbia has led to the commitment of those acquitted by reason of insanity until (1) their sanity is recovered and (2) they will not in the reasonable future be dangerous to themselves or others. The authors insist that the above require psychiatric definitions of an operable concept of dangerousness and they correctly conclude that not until such predictions can be made can the policy questions concerning what degree of risk should the community bear and how many false positives are acceptable be answered.

To be able to predict dangerousness is related to the basic capacity to understand disordered behavior, and to intervene in those circumstances where the result is an increase in social good, where society's members are reasonably protected, and where effective rehabilitative efforts can be made.

A myth and a misconception stand between the problem and its possible solution. The myth is that of individual clinical judgment which demands that each case be taken in its own right. Nevertheless many authors<sup>10-12,20,21</sup> who can recognize a need for the prediction of dangerousness insist on individual clinical judgment, intuition, and unexplained hunches. Spiegel,<sup>22</sup> who deplores a lack of research in the development of techniques for intervention, ignores prediction even though it underpins intervention.

The misconception is that particular psychiatric disorders are per se dangerous which is encouraged by certain mental disorders being characterized by some kind of confused, bizzare, agitated, threatening, frightened, panicked, paranoid, or impulsive behavior. That and the view that impulse (ie, ideation) and action are interchangeable support the belief that all mental disorder must of necessity lead to inappropriate, antisocial, or dangerous actions. In a staff report to the Commission on the Causes and Prevention of Violence, Erwin and Lion<sup>23</sup> note that "violence refers to assaultive or destructive acts or ideation. The term ideation is included because patients with fears and fantasies of violence sometimes act them out." Later they make a very doubtful unsubstantiated statement connecting violence with psychological disorder: "... our impression has been that the largest group of patients complaining of violence fall into the classification of 'borderline' or 'schizoid' personality types."<sup>24(p.1147)</sup> Another author, Muller<sup>25</sup> while arguing that "more specific criteria need to be established for imposing involuntary mental hospitalization," and the "degree of likely damage must be great," then states his criteria: "These are the psychoses, both functional and organic, and conditions in which there is permanent or temporary impairment of

cerebral cortical functioning so that at the time, the person is not considered fully responsible for his own behavior." Thus, the author confuses psychosis and/or the absence of responsibility with dangerousness. The argument is not very compelling. The criteria remain vague and inaccurate. Part of the problem may be that psychiatrists use mental disease as a concept which relates to treatment as Shah noted<sup>26</sup> and labeling of deviancy as mental illness or predicting dangerousness is just a convention to get someone to treatment. Once in treatment the concept dangerousness is forgotten. It is a device which enlarges and thereby confuses the apparent size of the problem. The confusion of serious psychological impairment and dangerousness and the dialogue of misunderstanding between the law and psychiatry about this is best illustrated by the following exchange (Hough vs United States, 2 F2d, 458 [1959]):

(Dr. Karpman): I urged her father to hospitalize her; but of course he wouldn't do it. I predicted, I told him personally that she never can tell what measures of what a person of this type of psychosis might do. It may be something very drastic. But I didn't think of murder, because I am not an astrologer and I couldn't predict in advance; but I said something drastic might happen.

Q: You thought she had a psychosis at that time?

A: Yes.

Q: What psychosis?

A: Paranoid schizophrenia.

Q: In your opinion, is Edith L. Hough the aggressive type of paranoid?

A: Yes, she is the aggressive type—as evidenced by the fact that she took measures of her own in killing the man. That is aggressiveness.

Q: In your opinion, is an aggressive paranoid potentially dangerous?

A: It is conceded universally an aggressive paranoid is dangerous. I would say that universally we think that any paranoid schizophrenic is potentially dangerous, because one can never tell when the meekness and submissiveness may suddenly turn around and become aggressive.

Q: Would you say that Edith L. Hough at this time is dangerous because she has schizophrenia, paranoid type?

A: I would rather not answer this question directly. Ask me whether a paranoid schizophrenic is potentially dangerous and I would say yes.

Q: You would say yes?

A: Yes.

In his testimony the psychiatrist states he can, and yet he cannot predict dangerousness.

Arguments about dangerousness are frequently circular, and so before proceeding there should be some agreement about what kinds of behavior are sufficiently threatening and damaging to be called dangerous. The National Commission on the Causes and Prevention of Violence defined violence as "overtly threatened or overtly accomplished application of force which results in the trying or destruction of persons or property or reputation or the illegal appropriation of property."<sup>27</sup> Katz and Goldstein<sup>28</sup> attempt to list the kinds of violence that might be assumed under the heading of such injury to persons:

1. Crime for which defense of insanity invoked
2. All crime
3. Felonies
4. Crime for which maximum sentence given
5. Crimes categorized as violent



- Crimes that are harmful, physical or psychological
- Any conduct, harmful or threatening
- Conduct provoking retaliation
- Violence toward self
- Any combination of the above

This list does not exhaust the possibilities. While too inclusive, this begins to define the possible boundaries. For my purposes I would limit the concept to that of injury and destruction of persons. These will be limited to include four index crimes against persons: (1) criminal homicide, (2) forcible rape, (3) robbery, and (4) aggravated assault.

I have excluded auto fatalities, the leading cause of accidental death. While the violent results of organized crime are included in the above categories, prediction in these cases relates to other factors than will be dealt with in this paper. Disorderly conduct, assault and battery, and other crimes are excluded unless they lead to serious harm. All these are excluded because the dangerousness is not clearly defined or, as for example the problem of auto fatalities and organized crime, require examination in their own right. Suicide has also been excluded because I intend to deal only with dangerousness to others, knowing that the problem of suicide is not so easily isolated as doing harm to others. The four index crimes are defined as clear categories in which undeniable serious harm is done to another person. Having then reduced the scope of dangerousness to the violence toward others subsumed under the crimes noted, we can ask—with what degree of certainty can we establish the likelihood of that behavior occurring within a certain time.<sup>19,20</sup> In a series of cases concerning the dangerously mentally ill, both in relation to civil commitment and persons accused or found guilty of "violent" crimes, considered in the United States Court of Appeals, District of Columbia Circuit, the character of the danger has been refined from 1958 to 1969. First the concept of reasonable foreseeability (*Rosenfield vs Overholser* 522 F.2d, 34 [1958]). That is, the dangerous act must occur in the community in the reasonably foreseeable future.<sup>21</sup> Not only must the dangerousness occur soon, but it must be based on a "high probability of substantial injury" (*Milburn vs Harris* 406 F.2d, 964 [1968] and *Cross vs Harris* 418 F.2d, 1095 [1969]). Thus, the term dangerous to others cannot be simply a way of singling out anyone whom we would prefer not to meet on the streets. Possibility of injury is not enough, it must be likely, and the threatened harm must be substantial (refer to the three cases cited above). Thus, the psychiatrist must define "likely" as meaning "virtual certainty," (as in the cases cited above) rather than mere chance.

What information is available about such dangerous behavior and its genesis that might be helpful in making predictions about its (re) occurrence with some validity within these definitions of dangerousness? What are the characteristics of danger and what are their relative weights in assessing the probabilities of such behavior? Unfortunately the literature is sparse, disorganized, and impressionistic.

Violent crime is primarily a phenomenon of larger cities, youths, who are for the most part male, uneducated, and black. There are certainly criminogenic forces such as

poverty, inadequate housing, overcrowded living conditions, poor employment opportunities, reduced family functions, and broken homes which can be implicated as forces in that particular population at risk. Yet these demographic characteristics, while indicating some direction that can be pursued to reduce or remove criminogenic factors, do not help in developing subpopulations in which predictions of dangerousness (as defined above) have any reliability much less validity. Sociological concepts such as criminal subcultures, opportunity, deviant role models, and a lack of "stake" just as anthropological explanations related to territoriality and the frustration-rage continuum have no predictive value. Violence is a form of social interaction, and attitudes to it are learned. For that reason culture provides the triggering mechanism in human aggressive response to frustration, just as it provides inhibiting mechanisms.<sup>22,23</sup> The data<sup>24</sup> that the United States has a culture that appears to celebrate violence may help explain the comparatively larger numbers of violent crimes in this country, but in itself has no predictive value.

The reported association of violent crimes with biologic defects has not been persuasive. Episodic dyscontrol with violent behavior has been associated with minimal brain damage<sup>25</sup> and temporal lobe disorder and seizures.<sup>26</sup> Chromosomal defects (XYY) and even testosterone overproduction has been implicated.<sup>27</sup> In these cases the presence of these defects in known criminals has no predictive value in their possible future violent behavior and at best can be found in from 10% to 50% of the known (apprehended and found guilty) criminal population samples studied. The prior crime of robbery by an individual is more predictive of the reoccurrence of that crime than any of the biological factors.

Psychiatry and psychoanalytic theory and studies have given very conflicting evidence<sup>28,29,30</sup> having no predictive value. Hypotheses concerning a "destructive drive" are used as to develop models to explain human development, particularly the effect of fantasy on conflict and resultant inhibition rather than action. Notions such as "destructiveness is probably at its most perfect in early childhood and all later manifestations are, for most people, dilutions or mitigations,"<sup>31</sup> which describes the theoretical civilizing of destructive impulses, and "... there is one representative of the destructive instincts that is accessible to observation, mainly sadism,"<sup>32</sup> as well as "the destructive instinct appears most clearly in negativism"<sup>33</sup> seems to be describing either violent fantasy or action which is not truly violent. Glover, in his collection of psychoanalytic studies of crime, states<sup>34</sup> (pp 349-350) "... the potentially antisocial and violent child is one of the most easily detected educational problems," and "Although so far it is not possible to predict exactly the form of delinquency it will take, a fair estimate as to whether crimes of violence were likely to occur could be arrived at. . . ." Again "destructive" is used more in its ideational sense rather than as describing action. From that an unwarranted connection is made between such ideas and possible delinquency; after which delinquency and violence are equated.

The nature of innate aggressivity in man, if it exists, has yet to be fully explored, and the vicissitudes of such a

drive and its possible relation to violence has yet to be described and understood. Operational relationships between the concepts of anger, hate, rage, and violence, are poorly differentiated. In a recent article attempting to do just that, Rothenberg<sup>13</sup> states "regardless of the explanation it is a consistent observation that the most truly violent people are those who have difficulty dealing with angry feelings," and then states predictively that "Therefore, there are predispositions to anxiety and anger in relation to particular situations and persons or classes of situations and persons. Such predispositions are so constant and predictable that they may be considered to be structural features of the personality that tend to instigate violence."

It is repeatedly noted that violence and violent crimes are associated with childhood familial brutality and violence.<sup>13,14,15</sup> Duncan and Duncan<sup>16</sup> feel it has predictive value stating, "a history of parental violence remains a significant consideration in evaluating homicidal risks," and they then go even further in predicting that should the hated brutal patient be killed and the offender be sane and immediately apprehended, he would be "minimally" expected to kill again. A number of authors<sup>17,18</sup> have reported that the triad of enuresis, fire setting, and cruelty to animals in children is predictive of adult crime. In one study of 84 prisoners, three fourths (75%) of 31 charged with aggressive crimes (felonies) had the triad, while of 53 charged with misdemeanors and minor felonies 28% had the triad. While the difference is significant within a prisoner population, its predictive value seems minor at best, and what of the nonprisoner population with this triad?

The abuse of alcohol<sup>19,20</sup> and drugs (amphetamines<sup>21,22</sup> in particular) have been implicated in violent behavior, and some have sought to prove that those particular drugs are the cause of violent crime. While their use may be associated with persons who engage in violence and violent crime, it is more likely<sup>23</sup> that a particular predisposing personality is necessary. The nature of that personality and what triggers violence is unknown. Blum,<sup>24</sup> in a compelling study of drugs and violence in a Staff report to the Commission on the Causes and Prevention of Violence, finds that one cannot link amphetamines to crimes of violence, sexual crimes, or accidents. Drugs do act as releasers or facilitators and in that sense can trigger violence in a person predisposed to it. Megargee<sup>25</sup> in a critical review of theories of violence shows that, as seen above, few studies test theories of human violence. Empirical studies do not test such theories. When such theories are tested they often focus on milder aggressive behavior or use infrahuman subjects. An exception is the work of Palmer<sup>26</sup> in which he did an empirical study of a prediction from a deduction of a theory of aggression. He interviewed the mothers of convicted murderers and discovered that for them the incidence of childhood frustration was significantly higher as compared to their next older brothers. A small start. It would be helpful if many such studies were attempted and more data collected. Nevertheless what is strikingly clear is that there is no unidimensional topology of violence.

What about the possible relationship between mental illness and violent acts? Certainly a strong relationship is

implied. Nevertheless, epidemiological data indicate that (1) the major mental illness rates are not comparable to violence rates and (2) the distribution of major mental illness is not the same as the distribution of violence. Szasz<sup>27</sup> goes further stating "... there is no evidence that mental patients are a greater source of danger than are mental patients, ... and that (the) myth lingers partly because of our tendency to ascribe mental illness to individuals who have engaged in aggressive or destructive acts. Szasz's solution is an administrative one—"Lawbreaker irrespective of their mental health, ought to be treated as offenders." Thus by calling them a different name, the issue of mental illness and dangerousness is side stepped. Much of the psychiatric literature prior to 1950<sup>28</sup> indicates that mental patients were less of a risk for violence than the general population. Most recently, Ekblom,<sup>29</sup> in a book published in 1970, took the position that the evidence in Sweden was that the risk injury to others from mental patients was less than in industrial employment. Three recent studies<sup>30,31,32</sup> in 1965 through 1967 in the United States take a very different view. Rapoport and Lassen<sup>30</sup> in a study of two cohorts of male patients discharged from Maryland psychiatric hospitals—708 in fiscal 1947 and 2,152 in fiscal 1957, challenge the findings of early studies. In comparing the rate of arrest for their patients five years prior to and subsequent to hospital admission, they found the patients' arrest rate equal to, and for some crimes (notably robbery), greater than that of equivalent years for general population of Maryland. A parallel report<sup>31</sup> of data for two cohorts of released women showed a particularly high rate of aggravated assault, as opposed to the high incidence of robbery which characterized men. Giovannoni and Gurel<sup>32</sup> followed 1,142 released male psychiatric patients (out of hospital for at least 30 consecutive days and alive four years after admission) from Veterans Administration hospitals in California and found that of that group, 156 expatients were involved in a total of 192 incidents of socially disruptive behavior with the ex-patient rates for homicide, aggravated assault, and robbery exceeding the general population 20, 3, and 1.5 times respectively. What of the threat of violence as made by mentally ill patients who have not committed crimes? The difficulty in the prediction of dangerousness is immeasurably increased when the subject has never actually performed an assaultive act. This is particularly relevant to involuntary mental hospitalization and to proposals for preventive detention without bail of persons accused but not convicted of crime.<sup>33,34</sup> Macdonald<sup>35</sup> in a study of 100 patients who had made homicidal threats, 21 months after the study began and when all of the patients were released, knew of only one former patient who had committed murder. The idea of incarcerating 99 in order to prevent the one murder seems a very high price to pay for the prevention of violence. These negative data support Morris and Hawkins<sup>36</sup> who correctly state "at present there is no operable concept of dangerousness, and when it is used it usually is for retributive purposes." For our purposes then, we will not attempt to consider dangerousness in persons mentally ill who have not committed an act of violence. Can we start with the mentally ill criminal? If we can make such predictions, it has im-



in the criminal justice system in relation to distinguishing different kinds of criminal problems, so that rather than the indiscriminate mixing of different populations in prisons, rehabilitation can occur in relation to appropriate prison subpopulations." It has significance for liberties insofar as present methods of defining dangerousness consist of mixes of discretion in sentencing, paroling, habitual and dangerous offender laws, and psychopath laws, all of which do not successfully distinguish the dangerous from the social nuisances and keep people in prisons for excessive periods of time. The individual and social costs are high and the policy issues relating to civil liberties and what degree of risk the community can accept are never met.

The question of where to begin was answered in part by events: one, in New York when the United States Supreme Court decided (*Baxstrom vs Herold*, 383 US, 107 (Feb 23, 1966), that 650 mentally ill criminals in the Jannemora and Matteawan Hospitals for the Criminally Insane had been denied their equal rights as guaranteed by the 14th Amendment to the US Constitution. All of these mentally ill had been kept beyond the expiration of their sentences. All had been accused and/or found guilty of defined violent crime, and all were predicted as being dangerous if released. That was the reason for their continued incarceration beyond their imposed sentences. After that court decision, many were sent to civil mental hospitals from which they were released to the open community. A report<sup>2</sup> on 72 men sent to the Central Islip State Hospital (New York) indicates that as a group they presented no different problems than "regular" mental patients. Also, "the data showed that the diagnosis of psychosis is neither necessary nor sufficient reason to anticipate destructive behavior."<sup>3</sup> The natural history of these men, over 200 of whom have been in the open community in the past two years, will serve as data about a large population of diagnosed dangerous mentally ill criminals many of whom now are living in the open community and whose behavior can be observed, violent or not. These empirical findings, when correlated to personality factors and precipitating circumstances will be the first quantitative data of a significant subpopulation at risk of engaging in violent behavior.

The second was in Illinois where a number of prisoners were found to have been retained in the Illinois penitentiary system by "administrative error" beyond the date, after 1941 through 1943, when they were to be transferred from prison to the mental health system.

Some of the legislative background is as follows. The Psychiatric Division of the Illinois Penitentiary system, located on the grounds of the Menard Branch of the State Penitentiary near Chester, Ill., was created in 1933 by an act of the State Legislature which consolidated and reorganized the state penitentiary system. Prior to this reorganization, the mentally ill within the prison system were referred to the Illinois Asylum for Insane Criminals, also at Chester, Ill. The asylum, established by the State Board of Charities in 1889, housed dangerous mental hospital patients, mentally ill convicts from the prison system, persons found incompetent to stand trial, and persons found to have become insane after a verdict of guilty but before

judgment or sentencing were also transferred to the psychiatric division.

The asylum building was turned over to the predecessor of the Department of Mental Health; and the name of the facility was changed to the Illinois Security Hospital. (In 1933, the state agency responsible for care and treatment of the mentally ill was the Department of Public Welfare. This department has since been reorganized and the responsibility for the mentally ill in Illinois now lies with the Department of Mental Health. In this paper, for convenience, this change in name will be ignored. Throughout, the Department of Mental Health will be cited as the responsible agency. Likewise, although in 1933 the state prisons were the charge of the Department of Public Safety, the currently responsible agency, the Department of Corrections will be cited in this paper.) This new facility was to treat two classes of persons: dangerous mental hospital patients already housed in the asylum or subsequently transferred from state hospitals, and those persons found incompetent to stand trial.

This initial scheme was operative until 1937 when the State Legislature amended section 12 of Division II of the Criminal Code and provided that those persons found by a jury to be not guilty of a crime by reason of insanity be committed to the custody of the Department of Mental Health. In 1941 this section was amended again to require that such persons be housed in the Illinois Security Hospital. In 1943, the section was amended once more to make the change retroactive, requiring all persons found not guilty by reason of insanity but confined to the Psychiatric Division to be transferred to the Illinois Security Hospital.

In 1968 it was discovered that the required relocations had not been carried out in several cases—"the Menard 18." The details of the original assignment errors are clear from the following discussion of 17 of these transferred inmates. It appears that one person found incompetent to stand trial prior to the 1933 reorganization was wrongly transferred from the Asylum to the Psychiatric Division in 1933. Six others found incompetent after 1933 were incorrectly assigned to the Psychiatric Division rather than to the Illinois Security Hospital. Six persons found not guilty by reason of insanity before 1937 and correctly assigned to the psychiatric division were not transferred to the Department of Mental Health as required by the 1943 amendments to the Criminal Code. And three persons found not guilty by reason of insanity were mistakenly assigned to the psychiatric division after the 1943 amendment. (It has been informally reported that this situation was made known to a former director of the Department of Public Safety some time ago. But, according to this report, he was reluctant to order the necessary transfers because of the reorganization of the Department of Mental Health and the voting on a bond issue in process at the time.)

Explanations for these oversights have never been offered, but one source of misunderstanding may have been the statutes themselves. Although the amendments of the Criminal Code requiring assignment or transfer of persons found not guilty by reason of insanity to the Department of Mental Health were quite clear, the correspond-

					Summary
Case No.	Age, Race, Marital Status	Crime	Event	Status	
1	64 N Single	Aggravated assault	Struck and cut two women with knife	Not guilty insane, 1914	
2	62 W Single	Robbery	Unknown—held up store	Not guilty insane, 1914	
3	75 N Single	Assault to rape	Pushed white girl to ground	Not guilty insane, 1914	
4	46 N Single	Murder	Apprehended in vicinity of murder	Unable to stand trial insane, 1914	
5	46 N Single	Murder	Apprehended in vicinity of murder	Incompetent to stand trial 1942	
6	64 W Single	Indecent liberties with a child	Seen with 4-year-old girl	Not guilty insane, 1914	
7	72 W Married	Aggravated assault	Shot wife three times	Incompetent to stand trial 1939	
8	55 W Single	Arson	Set fires, masturbated	Incompetent to stand trial	
9	85 W Married	Murder	Killed (shot) physician	Not guilty insane, 1914	
10	61 W Single	Aggravated assault	Attacked neighbor woman with knife	Not guilty insane, 1914	
11	77 W Unknown	Murder	Unknown	Incompetent to stand trial	
12	82 W Married	Aggravated assault	Shot policeman in foot	Incompetent to stand trial	
13	60 W Single	Murder	Killed mother (who was a mental patient)	Incompetent to stand trial 1937	
14	66 W Married	Murder	Shot and killed fellow worker	Incompetent to serve sentence 1944	
15	54 W Married	Murder	Shot and killed fellow worker	Incompetent to stand trial, 1939	
16	79 W Married	Assault to rape	Attempted robbery and rape, woman	Not guilty insane, 1914	
17	48 W Single	Robbery	Gas station \$31	Sentenced 1-2-37 vacated not insane, 1941	

ing changes in the Penitentiary Act were somewhat confusing. In 1933, section 111 of the Penitentiary Act listed persons found by a jury to be not guilty by reason of insanity among those to be confined in the psychiatric division. When the provisions of the Criminal Code were changed, this section of the Penitentiary Act was amended to include, as it does today, "all persons committed to the Department of Corrections as having committed a criminal act while lunatic or insane." Section 113 repeats this language, stating that such inmates will be released when recovered. Although it is not clear exactly to what class of persons these provisions refer, it is easily seen that they may have been misinterpreted to justify

continued placement of persons found not guilty by reason of insanity in spite of the clear requirements of the criminal code.

With subsequent investigations and cooperation between the Department of Mental Health and the Department of Corrections, these 17 inmates were transferred to the Department of Mental Health. I had the opportunity to see these "17" men while still in prison and to follow them for 2½ years after their leaving the Psychiatric Division of Menard Penitentiary. It is a somewhat distressing fact that in spite of the administrative misplacement of 18 men, I have never seen or heard of more than 17. A summary of my contact with each of the "Menard (18-1

Admission, Final Diagnosis	Final Prison Diagnosis	My Diagnosis	Disposition
mental dementia paranoid	Chronic dementia praecox	Mental deficiency moderate-severe	Chicago State Hospital and then a Nursing Home
epsey	Chronic brain syndrome with psychotic behavior	Chronic brain syndrome with seizures and partial deafness	Chicago State Hospital
with deficiency	Mental retardation	Mental deficiency, moderate	Dixon State Training School for the Mentally Retarded Died 7/26/69: death due to gastric carcinoma
chronic stupor depressive psychosis and type	Psychosis, atypical type	Chronic undifferentiated schizophrenia	Tinley Park Mental Health Center, sent home, and then sent to Manteno State Hospital
praecox, and type	Schizophrenia, hebephrenic type	1. Schizophrenia, paranoid type 2. Phenothiazine toxicity	Manteno State Hospital Died 10/26/70: death due to coronary occlusion
deficiency criminal tendencies	Mental deficiency psychopathic tendencies	Mental deficiency, severe	Lincoln State Training School for the Mentally Retarded then sent to Kankakee State Hospital Died 2/16/70: death due to gastric carcinoma
praecox, and type	Dementia praecox, hebephrenic type	Paranoid psychotic reaction	Chicago State Hospital then sent to Elgin State Hospital Died 9/18/69
praecox, and type	Dementia praecox	Schizoid character disorder	Manteno State Hospital
praecox, and type	Chronic brain syndrome with paranoid state	Paranoid state in remission	Manteno State Hospital
stupor	Schizophrenia, catatonic type	Schizophrenia, catatonic type	Chicago State Hospital
praecox CNS disease	Chronic brain syndrome, left hemiplegia	Severe brain damage: cause unknown	Chicago State Hospital Died 10/11/68: death due to pneumonia
praecox, and type	Paranoid psychosis amputation of left leg	Schizophrenia, paranoid type partial remission	Manteno State Hospital then sent to the Danville (Ill) VA Hospital
praecox, and type	Dementia praecox, hebephrenic type	Chronic undifferentiated schizophrenia	Manteno State Hospital
and type	Paranoid state	1. Paranoia in remission 2. Phenothiazine toxicity	Illinois Security Hospital then Elgin State Hospital: after a trial 4/18/70 he was placed in a nursing home
oid state adequate stability	Schizophrenia, paranoid type	Possible psychotic reaction in remission	Alton State Hospital then sent home
praecox, and type	1. Chronic brain syndrome 2. Bilateral cataracts	1. Senescence 2. Bilateral cataracts	Chicago State Hospital then a nursing home
praecox, and type	Dementia praecox, hebephrenic type	Chronic undifferentiated schizophrenia, partial remission	Peoria State Hospital

is given in the Table.

#### Comment

The Men.—The 17 men spent a cumulative 425 years in prison, after legislative remedy should have resulted in their being placed in treatment or community settings. This was based in part on some inconsistencies in the law, but more likely on the stereotypes of dangerousness with which they had been labeled and which had been constantly reaffirmed by their examiners. Shah<sup>22</sup> has indicated that there are many problems in the defining and labeling of deviant behavior—mental illness and dangerousness are both seen under certain circumstances

as deviant in our society; and their definitions are often more dependent on social rather than other contingencies. But, in addition, violence is accompanied by our evaluation of that act of violence because "violence is a form of social interaction on which some sort of damage is inflicted on one party by another."<sup>23</sup> Thus in retrospect, two of the men engaged in activity which, because of its nature, required a violent response. One, a 34-year-old black man with moderate mental deficiency, knocked down a 10- or 12-year-old white girl on a busy street during the day in 1927 and was charged with assault to rape. The other, a 34-year-old white man with severe mental deficiency, played with a four-year-old girl in 1938 and is charged



with assault to rape. A black man touched a white girl and a white man questionably molested a child. Both activities, at the time, considered very deviant and about which there were strong mores and sanctions. Both men were to be punished, but psychiatry offered the myth of treatment and mitigation of that punishment as they both are found not guilty by reason of insanity. Given both men and the circumstances, neither could be defined as mentally ill or dangerous.

Two of the men were convicted of robbery and murder, respectively, the details of which are not available. Yet neither was mentally ill at the time of their crimes. One had a seizure disorder and the other had a significant brain injury. The one with the seizure disorder was found not guilty by reason of insanity and served for 39 years; while the brain injured man was found incompetent to stand trial for murder in 1941. He certainly was competent in 1968 when I saw him just prior to his release and almost immediate death due to pneumonia.

The elderly man who had committed assault to rape and who at the age of 79, spoke freely of his crime and still felt remorse 37 years after the crime had been committed, was not mentally ill when I examined him. From the data, he was likely not psychotic or dangerous within a few years after his finding of not guilty by reason of insanity. Of all these men, he was the one who most likely recovered. That is, his mental illness was in remission within a few years of his imprisonment. He certainly was punished, insofar as he suffered for his crime, and was aware of the significance of that distress. Better than that, he recovered. Yet the system had no capacity to respond to that reality. What seems more likely is that the system redefines society's judgment of badness and continues to predict dangerousness in order to support that continuing definition.

Another of the men was sentenced to from one to 20 years for an armed robbery in which he took \$31. Unluckily for him, he was found not guilty by reason of insanity and spent 27 years in a prison hospital. He was surely psychotic then but when I examined him there was evidence of the psychotic process being in partial remission. How dangerous he was at the time of the commission of the crime or for a time after imprisonment cannot be determined. However, in this case it is clear that had he been given the opportunity for treatment and employment, he would not have been dangerous and most certainly would have been more socially competent than he is today. Evidence for present dangerousness is minimal. Evidence for anxiety is extensive.

One of the 17 made the mistake of killing a doctor. Insofar as he had to be examined by a physician in order to gain release and since the examining doctor became afraid of him, something abundantly clear from the clinical records, he remained in prison. This suggests that examinations and reviews without the examiner's knowledge of the prior crime can be a device for minimizing the social response to that crime which tends to contaminate the diagnostic process.

The man of this group considered most dangerous while in prison, was so categorized because infuriated by platitudes and being put off for 22 years about his wishes to be considered for release, he struck an assistant warden. Af-

ter that, he remained in handcuffs for three years and was overdosed with phenothiazine medication until the toxicity (dyskinesias) was apparent to any observer. After release from prison in 1969, he, who had been found incompetent to be sentenced in 1943, was found competent in 1970. His lawyer argued the novel idea that he had the right to elect whether the sentencing procedure would be governed by the laws in effect in 1943 or the present code. He chose to be governed by the latter. This avoided the problem posed by the 1944 jury recommendation that he be sentenced to life in prison. Sentenced to a term of 14 to 27 years for the murder committed on Oct 4, 1943, he was credited for time already served and released. His designation of dangerousness was conditioned more by his aggressive response to 22 years of being frustrated and patronized and the fact that the object of his aggressiveness was a prison official, than the nature of his prior crime, murder.

A young man set fires which destroyed property and potentially endangered lives. He was 25 years old when found incompetent to stand trial. It is not clear how dangerous he would have been if released but there is no doubt he could have stood trial sometime within the 3 years he spent in prison and that during imprisonment he was prevented from receiving any treatment that might have helped.

Four of the men had been and remained psychotic in striking ways, in spite of forceful although intermittent therapeutic interventions. One was no longer dangerous by virtue of his aging and other organic factors (he subsequently died on release). A second was probably never dangerous. It is uncertain that he committed the crime for which he was found guilty. Given his interested family he could have returned home and also been treated as an outpatient long before 1969 when he was released. That release was complicated because of the execution being postponed by reason of insanity in 1939. His status in relation to the courts is not yet resolved. Two of these men's behavior was difficult to predict because of their inaccessibility to examination and treatment. One of them assaulted a physician after his admission to a mental hospital in 1969. The other has settled into a quiet, almost somnolent existence in another state hospital. What is the difference if any between these two men? Both committed violent crimes, and both remained relatively inaccessible to examination throughout their imprisonment. That data inform us little of their dangerousness except that one or both may become dangerous if pressed too vigorously to recover by some psychological therapy. The relationship between prior violent behavior and the assault (the physician was pushed down) required further examination with the patient over considerable time in order to be understood. The behavior of the second patient, who has sunk into a torpor, does not mean that intervention would be hopeless or dangerous, but rather that it should be appropriate to the man and his problems and be correctly timed in its application.

What then about the prediction of dangerousness in this group of mentally ill who had "committed" crimes? Do we have a predictive capacity given this particular group of persons? First, from the data, it is not possible to establish



connection between mental illness and the nature of the crime committed. The relationship to dangerousness in the mentally ill is even more tenuous. If a mentally ill person is involved in or found near a violent crime, he is likely to be accused of it as well as found guilty. This is because of a pervasive notion that the mentally ill person is more likely to be dangerous and once so labeled, to remain dangerous. All subsequent examinations to predict dangerousness in the "Menard 17" were based on an original accusation of a violent crime, a stereotype of dangerousness, and a reaffirmation of the stereotype rather than data from the examinations. Dangerousness then is overestimated in the presence of mental illness, and/or by the nature of the "crime." Even the diagnosis of schizophrenia (schizotypia praecox) may be conditioned by the circumstances of the person's contact with the examiner, i.e., having been found guilty of a prior violent crime. Seven of the 17 men were diagnosed as having severe and dangerous mental illness without much evidence. Upon separation from prison, three of these have been re-diagnosed as nonpsychotic by prison physicians. The diagnosis in this circumstance is related to the condition of anticipated discharge rather than the prisoner's mental status. Aging certainly affects criminality, as do the pernicious effects of prolonged institutionalization. Crippling a man may certainly change a propensity for dangerousness—if he was dangerous in the first place. The method, however, seems usually cruel. But in addition, in the cases of two of the men, the imprisonment prolonged the illness, increased the instability, and possibly continued the dangerousness, if it existed, or conditioned its appearance if it had not existed at the onset.

What about the number of mental retardates in this group? It is hard to assess. Mental retardation may exist concomitantly with mental illness or alone. The retardation may be the peculiar social variety superimposed on the mentally ill by living in a total institution with little concern with care or expectation of the maintenance of social skills. Those persons who are mental retardates have evidence of both primary and secondary social deficits. Another reason they may be overrepresented in this study is that the mental retardate mounts a poor defense and is more likely to be caught (whether guilty or not) and sentenced. The retardate is then the beneficiary of a double benevolence. First, segregated for "treatment," and then kept in prison for their protection because in the free community they would fall prey to persons who would "use them."

Three of these men were never dangerous and probably did not committed any crime. Of these, one was psychotic and two were mentally retarded. Four had never been psychotic. Of that four, two, as noted, were mentally retarded and were not dangerous. The other two had both been involved in dangerous crimes, arson and armed robbery. Both could have served sentences directly, and in addition treatment could have been instituted quickly and rigorously; in the former psychological, and in the latter, medical. Two men were severely brain damaged, both were not dangerous since their first contact with the corrections system. Given some kind of sheltered setting they could have done better than in the many years they spent

in prison. Both died shortly after leaving prison. Five of these men had their psychotic symptoms partially remit in prison, and this trend accelerated upon release given the opportunity to be part of a more therapeutic setting. Five remained psychotic, two inaccessibly so. Of the 17, one may have been dangerous on release because of the inaccessibility and the catatonic features of his psychosis. At the time of release from prison, he was the only one possibly in that category. Of the rest who actually had committed a dangerous crime, there is little evidence in any of them to support continued dangerousness after two years of imprisonment.

**The Problem.**—In a sense, we have come full circle. We have viewed in microcosm, society's way of labeling some mentally ill criminals, overpredicting violence, and then acting on that prediction to exact retributive costs. From the data it seems likely that the poor, the mentally incompetent, the drifter, and the black are more likely to be labeled in this way for social reasons unrelated to any violent behavior but rather to society's need to find objects who represent projections of its own violence, or who can be scapegoated for a number of reasons. Scheff<sup>20</sup> has written persuasively about the labeling of deviants, and indicates that this process of categorizing is the single most important cause of a "career of residual deviance." Whether for reasons of anger, punishment, benevolence, or just chance, a number of social forces are set into motion which tend to not only support that label but in effect to shape the behavior of the labeled person so as to indicate the correctness of the original diagnosis and prediction. Other investigators<sup>21-23</sup> have shown that this occurs by controlling the amount and kind of information available for orientation to the labeled person. By so doing he can be led to embrace the attitudes which were entirely foreign to his original ways of thinking. In addition, social communications are used to define internal stimuli and the nature of communication to the labeled dangerous deviant is that he has little but dangerous wishes which require external control. Lastly, self-control is not automatic, but rather is determined in a large part by one's image of one's self. It requires propitious circumstances to operate effectively. Nevertheless in the circumstances of labeled dangerous deviance, eventually our self-image and the resultant self-control can function at low levels at best.

Given the present reality<sup>24,25</sup> it is unlikely that dangerousness can be predicted in a person who has not acted in a dangerous or violent way. From a preventive point of view,<sup>26</sup> it has been shown that gun control could reduce the number of fatalities resulting from acts of violence, but no body of knowledge about human behavior gives us the information to make predictions about potential initial violence. In fact, given the above work of Scheff, Blake, Mouton, Schachter, Singer and Shibutani, social forces are set into motion once labeling has occurred which are powerful enough to support the label of dangerousness, whether the original facts support it or not. Therefore, prior prediction seems to have dangers that outweigh its usefulness. Then what of the labeled deviant, the person who has presumably committed a violent act? It is critical that we develop methods to predict future dangerousness.

What is there in the data collected as well as what data can we continue to collect that will allow us to systematically determine dangerousness?

First we must be able to predict as much as possible free of the social system which has labeled the deviant behavior as dangerous and the social system which task it is to maintain the "residual deviance." We are part of the larger social system and cannot be free of it" nevertheless whenever possible predictions should be made by persons not within or supported by correctional, mental health, or criminally insane institutions, given their present roles in maintaining "residual deviance." It becomes clear that in dealing with the problem of prediction of violence, that as already has been known, the culture's view of, acceptance of, or sanctions against violence cannot be ignored, as the nature of society's institutional agencies for the custody, punishment, and rehabilitation must be taken into account.

Second, enough of the predicted violent as well as non-violent must be free to enter the open community in order that we can truly evaluate not only the correctness of our predictions but the factors that enter into the reoccurrence of or absence of a violent act, within a reasonable time after release from custody. Macdonald's data<sup>22</sup> should make us more willing to take that chance. What then are the factors and problems in predictions of future violent behavior? It is known that those who commit crimes of violence are associated with lower parole violations. Glazer et al<sup>23</sup> in a study of the violent offender and difficulties of parole prediction noted that homicide offenders have a 0.4% recidivism. Those with sex offender have 2.9% and those with assault 3.6%. The highest sex offense recidivism is for the nonviolent type. All of which means that the reoccurrence of individual violence is a relatively rare event, and the difficulty of predicting such an event is great. Eighty percent predictive accuracy is the greatest precision that has been demonstrated when applied to a cross-section of all prisoners who are considered for parole. How then can one begin to identify the less than 5% of potential parolees who may commit another violent act? Glazer et al<sup>23</sup> support the notion that prediction must be made before release and that long-term tabulations occur which relate the relevance of those predictions to post-release behavior. Also, he feels that his calls for the experimentation with the release of randomly selected prisoners. The accumulating evidence resulting from the Baxstrom vs Herold decision and the clinical data from the Menard 17 would support earlier release and further testing of predictive capacity. It is clear that the present response to violence or anticipated violence is a kind of societal "overkill."

What about the factors that may be implicated in the capacity to predict the reoccurrence of violent behavior? How can we weight the respective forces of biological determinants, such as XYY chromosomes, temporal lobe disorder, and certain mental retardations, given the vectors of certain demographic characteristics? While more work is required to determine the extent and relationship of these disorders in normal populations, it now seems likely that this may be a very small, special, and exotic population. It is critical to be able to distinguish such individ-

uals and provide those who can benefit with the special techniques available for their treatment. However, it is also likely that many persons who do not have these disorders are lumped into this group. The most extensive work on the subject<sup>24</sup> does not clearly separate the characteristics of episodic dyscontrol from episodic reaction, but rather forces distinctions, which do not exist as for example:

What appears at times to be hypochondriasis may be the result of somatic auras or episodic psychophysiologic reactions. Also there is mounting evidence that many of the bizarre, and at least superficially appearing motivationless aggressive acts, may be related to this "excessive neuronal discharge" or the potentiality for such.<sup>25, 26</sup>

How can we determine the strengths of impulse vs the degrees of control, and the particular social circumstances which inhibit or facilitate one or another or both? Studies by weighted questionnaire, to examine various aspects of impulse and impulsiveness are required. Then both experimental and natural settings (release to the open community) can be used to test and measure the degree of reactivity as related to the measured impulsivity.

What role does frustration play in aggression? Can it be measured? The work of Palmer<sup>27</sup> is a small beginning. More studies of both normal, criminal, and mentally ill populations are required. Then rating scales of emotional experiences, particularly on the frustration-aggression axis, need development and testing with each of the three populations noted.

Given certain possible outcomes of the relationships of the above to one another, how much alcohol and what kinds of dosages of drugs will act as sufficient facilitators? What about accidental factors? How much and what kinds of infant and child abuse are predictive of adult crime, and under what circumstances? The kinds of parents given to child abusing are reasonably well known,<sup>28</sup> and may give data useful in the prevention of such violence toward children. It is also known that adult child abusers were raised in ways similar to those that they have recreated with their own children. The necessary information still related to the question of how much and what kind of abuse to children leads to their adult violent behavior?

What is the predictive value of the childhood triad of firesetting, enuresis, and cruelty to animals? What weights to give to each alone and together? What feelings should one have for others, how much? What forms of mental illness in what settings result in violence? It should be clear by now that unlike the belief of some authors<sup>29</sup> criminality and mental illness are not the reciprocals of one another nor does one necessarily follow the other. Both can exist somewhat independently of one another in the same person, or in varied degrees of interdependence. The relationship of emotion or its absence to criminality and mental illness has yet to be charted.

What subpopulations of mentally ill are more prone to violence, and under what circumstances? How important is a violent fantasy—a threat? It may be that fantasy, as reported, or a threat, as uttered, may have little or no connection with acts of violence, at least not statistically. Again, more study is required. Except for the small study



Macdonald<sup>23</sup> the literature is barren.

What does the commission of a violent crime do to the possible weightings given above, and in what direction? What kind of interventions, how much, and for how long affect the weightings and in what way? Perhaps the empirical studies, and the isolation of various populations with various characteristics of danger, we begin to design morbidity-experience-prediction tables which can be tested by others. Then perhaps the performance of an event reoccurring can be stated with certainty, and then and only then can we responsibly face the difficult moral issue.

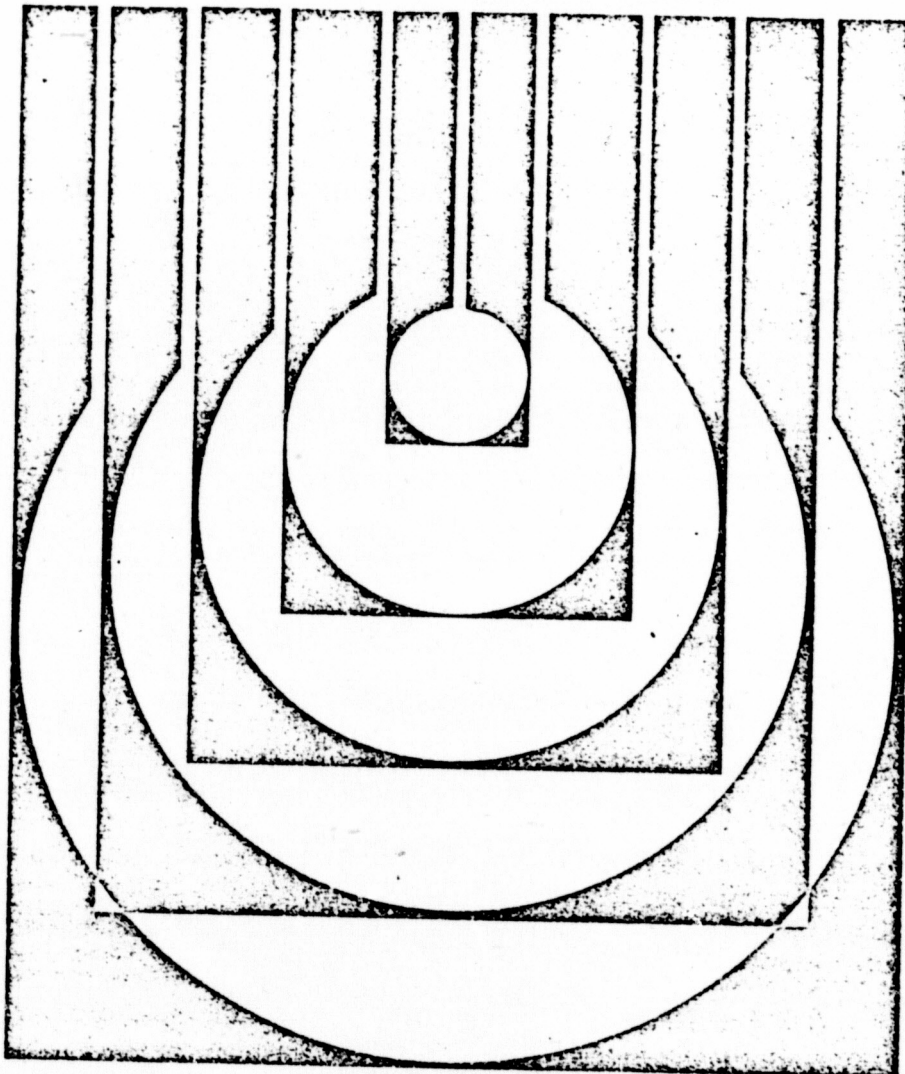
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**REPORT  
OF  
THE  
SECRETARY'S  
COMMISSION  
ON  
MEDICAL  
MALPRACTICE**

**medical  
malpractice**



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ing its application among the courts, and the law is in a state of flux. We believe that a uniform standard of disclosure would be helpful to the courts, the health providers and the public. Our earlier recommendation concerning the legal aspects of this matter appears in Chapter 4.

We perceive another possible problem: medicine today increasingly is being practiced not by one physician with one patient, but by teams of physicians and others. In such situations, multiple decisions may be required from several people. Should each of the providers involved in the chain of treatment of one episode obtain a separate informed consent from the patient? We do not know to what extent this is presently a problem, but we believe the situation should be watched as medicine comes more and more to rely upon team care.

Whatever the answers to these questions, uniform standards would go far toward giving both patients and physicians more understanding of where they stand in relation to the law.

*The Commission FINDS that the law relating to the nature of information which the health-care provider must supply to obtain valid consent for treatment is presently in flux. Adoption of uniform standards requiring full disclosure of material risks would eliminate much confusion as to the basis and nature of informed consent. Under such standards, both patient and doctor would gain a clearer understanding of their respective rights and obligations.*

### **The Dilemma of Full Disclosure**

It is difficult to determine the point beyond which the full catalog of risks would frighten patients and result in their refusing treatment even where the potential benefit would far outweigh the risk. It is also difficult to assess how much information can be transmitted without also creating such apprehension about possible side effects that even though treatment is accepted, recovery is hindered. Unquestionably, in some instances, informing the patient completely would do more harm than good. However, both for the patient's well-being and the doctor's legal protection, at least some responsible person who is close to the

patient should be fully informed and should help make the decision of whether or not to undergo treatment.

The Commission RECOMMENDS that a responsible member of the patient's family be given appropriate explanations where the physician is justifiably reluctant to explain such matters directly to the patient because of his concern that the explanation itself is likely to affect the patient adversely.

### **Access To Medical Records<sup>5</sup>**

One of the most hotly debated issues before the Commission was over the mechanics of the access of a patient to his hospital or physician medical record. The Commission was in agreement as to the basic right of the patient to know the nature and detail of his diagnosis and care. However, there was not unanimous agreement as to a right of unrestricted access to the medical record at the hospital or the physician's office. Although we agreed that neither the hospital nor the physician had the right to cover up, we differed with respect to what was in the best interest of the patient and his ultimate care.

The Commission ordered a study which indicated that in 41 states, if denied access to his medical records, the patient must resort to court action.<sup>6</sup> In the other nine states a variety of statutes have made the records available without resort to litigation.

The Commission recognized that the absolute refusal by the hospital or the physician to make the medical record available to the patient may, in itself, lead to unwarranted suspicion and possibly trigger a malpractice suit to gain access to the record.

*The Commission FINDS that the unavailability of medical records without resort to litigation creates needless expense and increases the incidence of unnecessary malpractice litigation.*

<sup>5</sup> See Dissenting Statement by Norma Almaraz.

<sup>6</sup> Access to Medical Records, Georgetown Law Center, APPENDIX.

## The Patient's Right to Medical Information

We believe that the patient has a right to the information contained in his medical record—whether that be the hospital record or his doctor's office record.

The majority of the Commission pointed out that a medical record in the hospital or the physician's office is far more than a series of entries reporting diagnoses, doctor's orders and actions taken pursuant to such orders. In the hospital setting the record is a complex of communications between health professionals, including a written history and physical, progress notes, nurses' notes, consultations, lab reports, operation summary, discharge summary, and the like. During the course of a particular hospitalization the record may include a wide spectrum of speculation and observation as the various members of the health team contribute thoughts and observations that lead eventually to the final diagnosis. If not properly explained, many of these entries could be exceedingly disturbing to a patient already apprehensive. However, to deter such entries could often eliminate the very clues that lead to successful diagnosis and treatment.

It is good medical practice for the attending physician to require such tests or diagnostic steps as may be necessary to exclude the possibility of cancer, even if remote, but the very suggestion of such possibility to many patients might adversely affect their path to recovery. Also, the health teams use a wide variety of abbreviations and phrases that can be both confusing and unintelligible to the layman. For all of these reasons, the patient, though he is entitled to information about his health and his care, needs guidance in understanding and using it. For reasons such as these, many physicians are reluctant to give copies of their records to patients. However, in a malpractice suit the records will be turned over for the patient's lawyer or medical witnesses to interpret as they will. The question, as we see it, is whether the patient should have to go to the extreme of filing suit to gain access to them.

Because of these complexities, we differed among ourselves on the point of whether the patient's "right to know" should be completely

unrestricted or whether it should have legal safeguards built around it. California provides that, although the patient does not have the right to direct access to the records, he may authorize his legal representative to examine and copy all or any part of the record without the necessity of filing suit. The rationale of this approach is that, although the hospital or physician could and would release the record directly to the patient in many situations, if there is doubt as to such release being in the best interest of the patient, then intervention of his legal representative would create an effective screening mechanism to assure proper communication and explanation.

Access through an attorney has much to recommend it, but the poor often have difficulty in obtaining legal services.<sup>7</sup> We agree that they should not be excluded from access to their records simply because they cannot get a lawyer to represent them. In some areas, legal aid groups are empowered to handle such cases, but in other areas they may be prohibited from working on any matter that could be fee-producing.

We believe there are techniques to deal with this restriction. For example, in Pittsburgh potentially fee-producing cases are referred to attorneys who will undertake the initial representation of clients for nominal fees, such as five or ten dollars. Such mechanisms, however, can be worked out only on a local level. We believe communities should make arrangements that would allow attorneys to represent indigent patients in gaining access to their medical records.

Among the nine states that allow patients access to their medical records without having to go to court, the statutes vary greatly:

- California, Illinois and Utah permit records to be examined and copied by the patient's attorney. The patient does not have the right to direct access.
- Massachusetts, New Jersey and Wisconsin explicitly or implicitly allow direct access to the patient himself.
- Mississippi requires a showing of good cause.
- Connecticut permits records to be examined only after the patient has been discharged from care.

<sup>7</sup> See our recommendation regarding legal assistance in Chapter 4.



We believe that some sort of uniformity must be brought into this area. At present records are not uniformly available, and there are differences in method in states which do not have appropriate statutes.

The Commission FINDS that patients have a right to the information contained in their medical records and RECOMMENDS that such information be made more easily accessible to patients, and the Commission further RECOMMENDS that the States enact legislation enabling patients to obtain access to the information contained in their medical records through their legal representatives, public or private, without having to file a suit.

A related problem area was brought to our attention during our public hearings. We were told of cases where it was proved that medical records had been altered to protect the hospital or the provider. We find this intolerable.

The Commission RECOMMENDS that the states enact legislation to prohibit modification, alteration or destruction of medical records with the intent of misleading or misinforming patients.

## Medical Research Involving Human Beings

An area of special concern to the Commission and one which we dealt with at some length, relates to the use of human beings in medical research. It is, to be sure, an aspect of patients' rights. Beyond the rights of individual patients, however, we see a broader need for guaranteeing the highest degree of ethical conduct in the carrying out of all such research, for the good of the general public. We firmly believe that protection of the rights and health of patients who participate in medical research is of vital importance. We also believe, however, that safeguards which are created must not stifle research so that future generations are deprived of possible benefits.

Medical research necessarily involves some hazards for the patients or subjects who participate in

the research. Despite prior testing with laboratory animals, the value and risks of a new medical procedure cannot ultimately be determined without testing it on human beings.

Although continuing medical research is essential for public welfare, the public good does not justify exposing individual patients to unwarranted risks. Moreover, no patient should be subjected to risks against his will. Guidelines for carrying out clinical research have been in existence for years.

The Commission believes that the World Medical Association's Declaration of Helsinki, and the Ethical Guidelines for Clinical Investigation adopted in 1966 by the Judicial Council of the American Medical Association represent effective standards for protecting the interest and welfare of individual patients or subjects without unduly hampering medical research.

The Commission RECOMMENDS that physicians engaged in clinical research consider as minimum standards of ethical conduct the World Medical Association's Declaration of Helsinki and the American Medical Association Guidelines for Clinical Investigation.

## Those Who Are Not Legally Competent

At times, medical research is oriented toward a particular class of patients, e.g. children, or the mentally retarded. The Commission believes that such research is vital and should be encouraged—under appropriate standards and guidelines—particularly in the pediatric age group, to assure the adequacy of therapeutic means for treating children.

We recognize, however, that there are special problems involved in medical research using children or adults who are not legally capable of giving an informed consent. It is important that the rights of both be protected. Important though it be that the search for new and better forms of therapy continue, there must be a careful balancing of interests and we believe that special measures should be employed to protect the rights of such persons.

The Commission RECOMMENDS that where clinical investigation necessarily involves the

participation of persons who are not legally competent to give valid consent, extraordinary precautions be established to protect the interest of such persons.

The Commission believes that the best guarantee of ethical standards of conduct in experimental medicine lies in the mental attitudes and prevailing values of the community of medical researchers. The competition for discovery and recognition by one's peers must not lead to unduly permissive behavior in the use of human subjects but must always operate within the framework of the medical profession's fundamental ideal: the relief of human suffering. These principles should be stressed throughout the period of training of all research scientists.

The Commission **RECOMMENDS** that the biomedical research community make every effort to educate its prospective members in the fundamental principles of research ethics.

## Federal Guidelines

In 1966, the Public Health Service (Department of Health, Education, and Welfare) began requiring all institutions applying for PHS funds for research to meet certain requirements. Since that time, it has been mandatory that all such proposals be reviewed by a committee within the research institution to determine that the rights and welfare of the persons involved are adequately protected, that the risks to an individual are outweighed by the potential benefits to him or by the importance of the knowledge to be gained, and that informed consent is obtained by adequate and appropriate methods. This review must be completed before the award of any PHS grant or contract that involves experimentation with human subjects. In addition, the committee must establish continuing review of the project.

Proposals are reviewed further by government advisory committees. If the proposal raises issues of undue hazards to human subjects, or, rarely, of clearly ethical issues, these are called to the attention of the institution that made the proposal.

The 1966 Public Health Service Policy on the

Protection of Human Subjects, now extended to cover all research funded by the Department of Health, Education, and Welfare, has been modified and expanded in the light of cumulative experience. We believe there is still room for improvement, especially in the implementation of the policy.

Although the Food and Drug Administration does not sponsor a large amount of research, it does have direct regulatory authority over the pre-market testing of new drugs on the part of the drug industry. In 1971 the FDA began requiring local committee review of drug tests. Its guidelines are identical to those used by PHS, but have the added requirement that the committees must include persons who are not scientists, such as lawyers, clergymen or other laymen.

There have been objections raised over the use in investigational medicine of subjects whose freedom to consent is questionable by reason of infancy, senility, mental retardation, ignorance or legal confinement. On the other hand, the medical care given these subjects is usually excellent, and often otherwise unavailable to them. Prisoners who volunteer as experimental subjects acquire a sense of personal worth and pride as well as material advantages.

The FDA requires that researchers testing new drugs agree to comply with the applicable HEW research policy. Here again, surveillance of actual compliance presents difficulties. In a 1969 test of the side-effects of contraceptive pills in San Antonio, Texas a group of women coming regularly to a clinic were, without their knowledge, given nothing but placebos. The researcher responsible for the San Antonio experiment is now conducting experiments in Latin America with a \$900,000 grant from the Agency for International Development. Written assurance of compliance with Department of Health, Education, and Welfare policy has been given. But, again, there is no monitoring of actual performance.

The Department of Defense conducts most of its research at large military installations. Conscientious objectors, paid volunteers and active-duty military volunteers are used as subjects. The Department also conducts clinical investigations in teaching hospitals. Many initial trials are done by the researchers on themselves.



The Veterans Administration conducts an extensive program of medical research in the VA hospitals. The Department of State's Agency for International Development funds research involving human subjects both at home and abroad. Both the VA and AID have adopted the HEW Policy on the Protection of Human Subjects.

The Commission believes that the HEW requirements should be applied to all medical research involving humans, whether done by the private sector or government agencies, and whatever the source of funding.

As a practical matter, this is already usually done—at least in the private sector. It is too complicated for institutions that receive HEW research funding to establish two different standards for developing studies. The custom that most institutions follow is to subject all research to the review committees required by HEW. The Commission urges that this practice be adopted by all universities and research organizations.

The Commission RECOMMENDS that the Department of Health, Education, and Welfare Guidelines on medical research involving humans be applied to all persons participating in medical research regardless of the source of funds which support the investigation.

## Compensation For Injured Research Subjects

Many persons who participate in medical research are healthy volunteers. Some others are patients who volunteer for tests of a drug or other therapy that will have no effect on their diseases. The Commission is concerned about compensation for such volunteers if they are injured in the course of treatment.

In the case of research conducted by the Federal Government, volunteers who are injured during experimental treatment are given free and continuing medical care. However, no additional compensation is paid unless the volunteer can prove negligence on the part of the investigator. The Commission believes that persons who volunteer to be research subjects should be entitled to compensation for injuries sustained as a direct

result of the experimental treatment, whether or not due to negligence.

In the case of Federally-supported research, the Commission believes that funds for this purpose should be included in the basic grant. Moreover, the same rules should apply whether the Federal Government supports research or whether research is funded solely by the private sector.

The Commission RECOMMENDS that whenever a grant or other funding is provided by the Federal Government for medical research involving human subjects, the grant should include a sum sufficient to provide either insurance or a self-insurance fund in order to provide compensation to any human subject who may be injured in the course of the research. Where the Federal Government itself conducts the research, precisely the same rules should apply, either through the Federal Employees' Compensation Act or other Federal funding sources.

The Commission RECOMMENDS that whenever research involving human subjects is conducted by the private sector that insurance be provided to protect against mishaps, injury or illness directly arising out of that research.

## Consumer Participation In Health Care Decision-Making

The preceding sections of this chapter have looked at provider-patient relations and various aspects of an individual patient's right to be informed concerning the nature and progress of his medical treatment. Patients are also consumers who have a unique knowledge of their health care needs and of the ways these needs should be met. Their participation in making the decisions which affect the delivery of health has the potential to improve both the quality of health care and their satisfaction with the health-care system.

Today an increasing percentage of the nation's health care is being provided through neighborhood health clinics, Health Maintenance Organizations, and the outpatient departments of hospitals. This institutionalized medicine tends to be far more impersonal than the care provided by the familiar family doctor, and many patients feel unable to make their needs and complaints effective.

tively known in these settings. Although many institutions providing medical care are governed by boards comprised primarily of laymen, these people are usually not chosen because they represent any particular group of patients. Rather, they tend to be persons who are prominent business, religious, governmental or social leaders of the community. While many trustees (if not most) are civic-minded individuals with a real interest in the role and responsibility of the hospital to the community at large, they are not typically representative of a cross-section of the community.

Consumer participation in health care services has grown out of the efforts of recipients of health care to influence the institutions providing health care to them. A variety of methods for consumer participation have been tried. They range from the patient advocate to persons who represent patients on hospital governing boards. By making patients, potential patients, or their advocates an integral part of the health care decision-making process, the patient's viewpoint is reflected in health care policy decisions aimed at improving the quality of care and increasing patient satisfaction. Better care and satisfied patients can go a long way toward reducing both actual malpractice and malpractice claims and suits not involving malpractice.

In recent years consumer participation in health care planning and delivery has been a goal of many consumers from diverse economic and social backgrounds. The demands of patients for a greater voice in the planning and delivery of their health care has been fostered by two factors. One, increasing dissatisfaction with the current system has caused many patients to believe that the health-care system should be changed and that consumers of health care should participate in making the changes. Two, the acceptance of consumer participation has been aided by the realization that many decisions involving health-care delivery do not require highly technical medical knowledge, but instead a knowledge of community wants and needs.

Advocates of consumer participation argue that health-care recipients should have a place in health-care planning because health care has an incalculable effect on consumers' lives, and because patients pay the bills, directly or indirectly, through taxes or insurance. Consumers also have

unique knowledge to contribute to the decision-making process. In turn, they learn more about the health-care system through their participation. The education of consumers increases the effectiveness of their participation and helps to make their expectations of the health-care system more realistic.

The mechanisms for consumer participation vary greatly. The success or failure in a particular situation, measured by increased patient satisfaction and improved quality of care, is linked more closely with the degree of control exercised by the consumers than with the particular method of participation. Where consumer participation has been meaningful, the result has been both greater satisfaction and improved health care.

The Commission was told that mere token representation may increase consumer frustration. If participation is to be meaningful and helpful, it must be at a level where the consumer can really influence the policies and management of health-care organizations and institutions.

Effective consumer participation does not end all frictions between health-care providers and patients or solve all problems of health-care systems. It is merely one way of reducing these frictions and promoting greater understanding and satisfaction—creating a climate which, the Commission was told, has the potential for reducing the number of otherwise unwarranted malpractice claims. Consumer participation also can result in improved patient care.<sup>8</sup>

*The Commission FINDS that where consumer participation has been successful, there has been a beneficial effect on the quality of health care and on increasing the satisfaction of the recipient community, which in turn has a beneficial effect on reducing the potential number of malpractice claims.*

*The Commission FINDS that the interests of health-care providers and the consumers are best served by effective consumer participation at the decision-making level.*

The Federal Government has, under various OEO and HEW funded programs, encouraged or

<sup>8</sup> See Separate Statement by Ella Strother.

required consumer participation in neighborhood health centers, comprehensive health planning panels and hospital planning bodies. The success of consumer participation in these programs has varied considerably. However, the Commission recognizes the potential consumer participation has for improving the quality of care and the need for continued exploration in this area.

The Commission RECOMMENDS that the Secretary of Health, Education, and Welfare and the administrators of other Federally-supported

health-care delivery and medical research and demonstration programs establish and continue consumer involvement activities at the planning, services, supervisory, management, and coordination levels by means of board membership, advocacy and advisory mechanisms.

The Commission RECOMMENDS that the same degree of consumer involvement be fostered by all appropriate non-Federal health-care delivery and research programs.<sup>9</sup>

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<sup>9</sup>See Dissenting Statement by Monroe Trout.



length of the residency is justified because these residents carry an unimportant hernia-equivalent load is failing to understand the nature of the training program. Unlike the situation in suburban private practices, the management of patients in the typical medical center is a team activity with many members assuming a portion of the responsibility. The load of complex work attributed to the fifth-year resident is not being carried by him alone; it is unlikely that it could be carried at all by someone who had not spent some extended period struggling with lesser responsibility on similar problems.

"What is rewarded in a culture will be cultivated there." With this phrase Plato may have been cautioning us to choose carefully the behaviors that we wish to reward by measurement. Perhaps what we should be measuring in practicing surgeons or residents is the *total* cost of the illness event to the patient: time away from work, time away from home, lost physical capabilities, and the financial burden incurred subsequent to entering a surgeon's or resident's care and continuing to full rehabilitation. This new measure of surgeon's worth, lowest gross cost (time, money, inconvenience and disability) to the patient, would emphasize quality of clinical judgment rather than quantity of operative work.

The alternative educational model thus developed would emphasize the full scale of decision making that leads to optimum surgical outcomes — diagnostic or nonoperative management and qualitative operative events.

The authors have urged that the study not be overinterpreted. We join them in that caveat. There may be too many surgeons, and too many residents in too many training programs. They may be overtrained and underutilized. Substantial reforms in our training programs may be justified. It is doubtful, however, if any such inferences are allowed by the descriptive data reported here. We must obtain more information about job opportunities and job characteristics for various specialties, about the changing nature of society's need, about the means for better educating surgeons for a lifetime of growing competence. Gratitude is due those who develop the tools for obtaining that information. But in analyzing and drawing tentative conclusions from the descriptive data that relate to those questions, more sophistication and care should be applied than has often been the pattern in the recent past.

College of Physicians & Surgeons  
New York, N.Y. 10032

THOMAS C. KING, M.D.

## SOUNDING BOARD

### GIVING THE PATIENT HIS MEDICAL RECORD: A PROPOSAL TO IMPROVE THE SYSTEM

DISSATISFACTION with the functioning of the medical-care system has become widespread. Four serious problems are

maintaining high quality of care, establishing mutually satisfactory physician-patient relations, ensuring continuity and avoiding excessive bureaucracy. We believe these problems could be alleviated, in part, if patients were given copies of all their medical records. The record to a large extent embodies the informational product of medical consultation and treatment. In most exchanges in society a purchased product becomes the property of the purchaser, who is then free to evaluate the product on his own, have it evaluated by experts and choose freely among suppliers for any further services. Patients, physicians and planners and administrators would all benefit if the conditions of open information and freedom of choice that prevail in the market were to be introduced into the area of medical care.

At present, medical records are not routinely available to either physicians or patients. In theory, records are transferable within the profession; in practice, they are seldom transferred even in summary form, and even within one institution. By law, patients can obtain their medical records in 41 states only through litigation, in three states only through an attorney although not necessarily litigation, in one through showing good cause, and in one only after discharge from care. Only three "explicitly or implicitly allow direct access by the patient himself."<sup>1,2</sup> It is indeed paradoxical that records are available primarily for setting the patient and physician against one another, and in most cases, only through the intervention of another professional!

## THE PROPOSAL

We propose that legislation be passed to require that a complete and unexpurgated copy of all medical records, both inpatient and outpatient, be issued routinely and automatically to patients as soon as the services provided are recorded. The legislation should also require that physician and hospital qualifications (accreditations, memberships, etc.) and charges for services be recorded.

Hospital records should be available regularly to patients on the ward, and copies sent to them upon termination of the hospitalization. Outpatient records could be issued in two ways: copies could be sent directly from the physician's office; or records could be stored and mailed centrally. Although the latter approach would generate more red tape, centrally stored records could provide data for epidemiologic studies, be co-ordinated with activities of Professional Standards Review Organizations, and ensure against loss of his records by the patient. In addition, central record storage would facilitate a patient's option to refuse or accept the record anonymously.

## EXPECTED POSITIVE RESULTS

The Proposal would benefit most participants in the medical-care system.

### Patients

*Information.* At present, patients generally receive insufficient information on their own case,<sup>3</sup> and their health knowledge is quite poor regardless of socioeconomic status, race, rural or urban background, age group or sex.<sup>4</sup> Both physicians and patients find this undesirable.<sup>5</sup> In addition, inadequate transmittal of understandable information from physician to patient largely accounts for the widespread phenomenon of patient noncompliance with professional recommendations.<sup>6,7</sup>

With record in hand, the patient would receive more complete information about his medical encounters, a source of satisfaction in itself. Patient compliance would probably im-



prove, since the available record would supplant reliance on memory and would help the patient understand the rationale for treatment. Better records might even result as patients corrected mistakes in the history, and were encouraged by seeing their case described to keep relevant symptomatic notes for the next visit.

The record would serve as an educational tool. Patients would consult books or medical personnel about unfamiliar words, and thus learn professional terminology and concepts. Eventually, increased knowledge would lead to more appropriate utilization of physicians and a greater ability of patients to participate in their own care.

**Continuity.** The effects of replacing the "whole-person" physician by many specialist referrals have been exacerbated by population mobility, frequent use of emergency rooms, and physicians who cover one another's patients. Even when referred from another physician, patients must give the same history time and time again (a necessarily faulty one, since they are forgetful and do not know the details of their past professional care), and submit to the same laboratory and radiologic procedures repeatedly, because records are not at hand.

In contrast to this situation, implementing the Proposal would always provide a physician direct access to the history of the patient's previous care, complete with base-line data, drug schedules (a major problem), hypersensitivities, etc. Patients would accordingly be subjected to fewer repeat tests, would be required to repeat but little information and would receive more complete, better informed care. The patients would at all times feel less "lost" in the system.

**Choice.** Patients have little opportunity to exercise informed free choice of physician in either primary or secondary care. The few criteria available for judging physician capability (e.g., specialty certification or hospital affiliations) are often unknown to patients or uninterpretable by them; they must use personalistic, nonprofessional criteria instead. Patients are inhibited from freely changing physicians, in part, by the expense of new work-ups, and by the difficulty of ever returning to the original physician if the new one should request the previous records.

Clearly, adopting the Proposal would free patients to choose and change physicians more easily. Patients would also be able to make better judgments about their physicians, and to differentiate legitimate physicians from quacks. Comparing physicians on professional grounds would become possible to some extent. It would take little sophistication, for example, for the patient to correlate a surgical procedure with the presence or absence of surgical-board certification (as listed on the record). A sophisticated patient might want to research the diagnosis himself, and learn more about it while monitoring the physician. Such personal attempts might have the side effect of emphasizing to a patient the difficulty of medical practice, and enhancing the physician's legitimacy as an authority (on the basis of official status combined with recognized expertise).<sup>8</sup>

Published guides to medical care would soon flourish, and professional consultant services for records "translation," interpretation and evaluation would arise in response to consumer demand. Medical societies, universities, private groups, or Professional Standards Review Organizations could operate such services, which would then function as noncompulsory, decentralized quality-enforcement mechanisms.

**Physician-patient relations.** The nature of physician-patient relations has conflicted with American cultural norms. Americans demand autonomy<sup>9</sup>; yet patients have been forced into profound dependency on physicians whom they

must trust on faith alone, whom they can hardly understand, and to whom they have often had little real alternative. As a result, many patients have acquired paranoid feelings about the medical-care system -- and acted on them. The Women's Health Movement takes matters into its own hands; the thriving business of quacks and cultists reflects a search for friendly attitudes in a hostile professional world, as well as the public's inability to discriminate on a scientific basis.<sup>11</sup>

Availability of records would enable patients to be much more autonomous in making judgments and choices; less dependent, they would feel less paranoid. The increase in patient information would undermine much of the current suspicion of physicians' candor. Since provision of medical records to all patients would be obligatory, no physician would regard any single patient as impeaching his services. As patients became more familiar with medical concepts, physician-patient communication would improve. All these improvements would produce more harmonious physician-patient relations.

### Physicians

**Quality care.** At present physicians have only limited means of evaluating one another's performance.<sup>12</sup> As a result, an incentive for practicing high-quality care is lost, and referring patients to other physicians of known competence is made more difficult.

An effect of implementing the Proposal would be decentralized peer review. After seeing several patients whom another practitioner had seen, in conjunction with their records, a physician could hardly help making an assessment of that physician's abilities and practice. In this way professional reputations would grow according to the concrete criteria of patient care. Anticipating this process, physicians would have a clear incentive to practice high-quality medicine, especially since the practices of the most reputable would probably increase. In many cases, favorable evaluation by a specialist of a primary practitioner's records, or vice-versa, would result in increased trust and more expeditious referral of the patient to the appropriate level.

In addition, the Proposal would provide physicians new opportunities to learn. Just as residents learn by caring for patients and observing how various specialists treat their patients after they themselves have done as much as they can, so physicians in whatever practice setting would have the same experience repeatedly. The freely available record would provide a more "longitudinal" view of a patient, and physicians would appreciate better (and treat better) the course of a disease. Since innovation proceeds mainly by the contagion effect, new knowledge would probably be put into practice more swiftly, and isolated practitioners reached more quickly.<sup>13</sup>

**Satisfaction.** Practitioners have become less satisfied with their role and status in society. One cause of discontent has been that professional prestige has centered around academic centers where scientific advances are made, and where articles published and rank achieved are convenient measuring rods. By contrast, practitioners have had happy patients and money to mark them as successful in the community at large, but these advantages have counted little within the profession.

Another source of discontent has been intrinsic to the practitioner's role. Specialization and discontinuity have frustrated practitioners trying to provide for a patient's needs. Moreover, the strains in physician-patient relations have affected physicians probably even more than patients, since being a patient is only a part-time pursuit.

Decentralized peer review would provide recognition of excellence in the practice of medicine, and hence enhance the prestige of being a practicing physician. Patient records and the care that they reflected would become a source of pride open to the perusal of fellow professionals. The expected improvement in continuity would decrease frustrations, and improved physician-patient relations would add importantly to physician satisfaction.

#### Planners and Administrators

At present, power in the health system is decentralized to the penultimate step — the physician. In the eyes of planners, administrators, fiscal intermediaries and the public that they represent, the physicians' autonomy is unchecked. Administrators and policy makers do not have the capacity easily to evaluate or control the appropriateness of medical care, nor have they been able to remedy such maladaptive forces as the drive for more and more physician specialization.<sup>14</sup> Increasingly, they are turning to comprehensive organizational solutions that call for increased centralized decision making and an increase in provider aggregations, such as Health Maintenance Organizations, foundations for medical care, neighborhood health centers, hospital-based practices, Professional Standards Review Organizations, and comprehensive health planning. Most of these solutions would deliver more power to the proposers of reform.

The layers of bureaucracy implicit in all these proposals have familiar drawbacks. Quality control from record review and other centralized mechanisms faces many practical limitations.<sup>15,16</sup> Increased centralization would probably decrease responsiveness to consumers because professionals would interact with one another more and patients less.<sup>17</sup> Attempts to ensure a consumer orientation in policy making as in some neighborhood health centers have had only mild success.

Adopting the Proposal would reduce fears about physician accountability and quality. Self-regulating, decentralized peer review would provide better individual assessments than centralized review, since reviewers could correlate the patient himself with the record, instead of merely checking its internal consistency. Both inpatient and outpatient records would be used, and information would be generated precisely at the points of usage — patients and colleague physicians. On the other hand, some functions of centralized peer review, such as standards setting, would not be pre-empted.

The Proposal's improvement of continuity would supplement rather than supplant current administrative initiatives such as defragmentation of services. In addition, the specialty distribution of manpower would probably become more appropriate: the new prestige and satisfaction offered practitioners would make manifest the latent desires of many medical students to become family practitioners. These improvements would all take place without an increase in bureaucracy, as patients were enfranchised by decentralization instead of partially disenfranchised by centralization.

#### OBJECTIONS TO THE PROPOSAL

A number of objections to the Proposal may be anticipated. To begin with, various objections could arise from so strong a reliance on records. Records could be falsified, and diagnostic and treatment procedures made to look more complete and exhaustive than they were. A reliance on form

rather than substance could develop, with no associated improvement in patient care.<sup>18</sup> Or, conversely, practitioners could be led to do too much and be too complete for the sake of self-protection. With records so public, practitioners might be less free to practice in the most expeditious way possible, and the record might become a real burden. Moreover, judgment of medical-care quality on the basis of records could penalize a good practitioner who happened to keep poor records.

Certainly, records could be falsified, although verification procedures and patient recollection would serve as a check. Adherence to proper form would have little chance of passing for substantive validity in this decentralized system, as explained above.

Less-than-adequate work-ups are more common than more-than-adequate ones, so that a correction of this tendency would be salutary. With records traveling predominantly in the medical realm, despite the patient intermediary, medically warranted shortcuts should prove acceptable.

Finally, it must be stressed that medical records are not merely more red tape like insurance forms. The medical record constitutes an integral and vitally important part of the medical-care process, formalizing and focusing medical logic as well as facilitating memory. If a practitioner can somehow convince his patients that he is good despite records deficiencies (as might be true rarely), the Proposal would allow this relation to continue unhindered, whereas more centralized and routinized procedures would not.

A second objection might be that peer review of any sort can be questioned. Since professionals rely on peers as their primary reference group, peer support may take priority over quality review. It is safer for them to measure adequacy by academic degrees achieved than by competence demonstrated. There is, furthermore, an almost pathologic fear among practitioners that their practices will be found deficient<sup>19</sup>; probably much of this fear is motivated by the absence of any previous reviews, the lack of continuing education and the residual effect of medical-school intimidation. Some is no doubt motivated by beliefs about malpractice settlements.<sup>20</sup>

Much of the unwarranted fear of review would be assuaged with experience. Moreover, decentralized review with voluntary sanctions might be easier to accept than centralized alternatives. Decentralized peer review should also be more effective since the medical profession is not really monolithic. After implementation of the Proposal any group could offer patients evaluation services and a majoritarian professional protective interest would accordingly be less effective, whereas the closed-door proceedings of centralized peer review would find dissenters excluded and overwhelmed.

A third possible objection would be fear that open disclosure of records would lead to more malpractice suits. What should be feared, however, is not more suits, but unjustified ones. The Secretary's Commission on Medical Malpractice has found that most suits are generated by poor patient care rather than greed and "... the unavailability of medical records without resort to litigation creates needless expense and increases the incidence of unnecessary malpractice litigation."<sup>21</sup>

A fourth objection would be that some might fear that physicians would be called upon to spend more time per patient, both in writing better records and in answering more questions.



Although this might be true for any single visit, productivity would probably not be impaired. Increased time spent on writing a record would be productive time, not wasted time, because the quality of clinical decision making both at the moment and in the future would improve (since other physicians would have a better longitudinal view of the patient). Additional time spent on patient education would likewise represent an increase in quality; moreover, the time presently spent (19 per cent of internists' time in one study<sup>21</sup>) would be used more efficiently. Proper patient education, improved continuity of care, and many of the other improvements anticipated to emanate from the Proposal's implementation would be expected to decrease the time per follow-up visit as well as reduce the number of visits per person per year. Even if spreading medical care as widely as possible were to take precedence over improving its quality, it is not clear that slighting medical-record keeping and health education would be desirable.

A fifth objection would be that implementing the Proposal might offer ammunition to patients who are already too directive with physicians. One motivation of such patients, however, is distrust of the professional's concern, and revealing the full record might curtail some of that distrust.

Sixthly, patients might misuse the records to treat (or mistreat) themselves — much self-dosing and pill borrowing already occurs. Making records available might well have the opposite effect, however, since the obvious discrepancies between various illnesses would be manifest. At any rate, the proper approach to the self-dosing problem is through tighter prescriptive habits and better patient education, both of which would be facilitated by the Proposal's implementation.

Seventhly, adopting the Proposal clearly would interfere with current practices of dealing with the patient with a terminal illness. At present, great discretion is allowed the physician in communicating the prognosis, and quite often he decides not to disclose it directly — in one recent study in Great Britain only 6 per cent of terminally ill patients were told of the prognosis.<sup>22</sup> Far too often, by all accounts, medical personnel handle the problem of the dying patient by avoidance and denial, whereas it would frequently be better for patients if the situation were confronted openly.<sup>23</sup> Still, flexibility would be possible. Circumlocution on the record would allow the patient to deny if he wished. The physician and patient could agree before the results were known to tell or not to tell. A patient himself could decide not to look. The only excluded possibility would be the physician's withholding information the patient desired.

Eighthly, psychosomatic disorders would present a similar problem. Direct communication of the physician's knowledge would be a distinct improvement in many cases. Still, the possibility that a disorder was of psychosomatic origin would usually be placed in a constellation of organic possibilities, and the emotional problem could be approached gently as the other possibilities were ruled out.

Ninthly, some might object, theoretically, on the grounds that the medical-care system should be organized to provide for care without patient initiatives. For example, the system, not the patient, should inform a dentist before he operates to give penicillin prophylactically to a patient with congenital heart disease.

Implementing the Proposal would supplement rather than contradict this precept. The patient should act as a backup; that safeguard will be necessary even after compre-

hensive systems have fully matured. In addition, patient contributions make any structured system more responsive and less bureaucratic.

Finally, the objection can be made that middle-class patients already have better access to physicians and more sophistication in dealing with them than poorer patients do, and the Proposal will only reinforce that advantage.

Although it is true that the middle class will be able to interact with physicians more effectively, and will be more mobile in switching physicians, it is also true that the poor receive care of much lower quality at present.<sup>24</sup> The lower class will be able to use some of the tools provided by the Proposal, and the overall effect on quality should benefit the lower class substantially. Given their present relative positions, which class would benefit more is not clear.

### IMPLICATIONS FOR GENERAL REFORM

The Proposal represents an incremental rather than a comprehensive change; its implementation should improve medical care at once and exert a salutary influence on the system's continuing evolution. Despite the fact that the Proposal promotes free communication and patient autonomy, it would not interfere with centralizing reforms, such as Health Maintenance Organizations and Professional Standards Review Organizations. On the contrary, as the evolution of socialist economic systems indicates, autonomous influences are sometimes essential even within administered systems.

More specifically, countries with tightly organized medical-care systems tend to have different expectations in physician-patient relations — Sweden is a good example.<sup>25</sup> If the United States system is to evolve toward more formal organization, care will have to be taken to structure that system so that our own preference in physician-patient relations will be preserved (or resurrected). In addition, the United States has a traditional respect for family practitioners often lacking in other countries; we would be well advised to nurture this functional attitude. The Proposal would contribute to preservation of both these positive qualities as our medical-care system evolves.

77 Prospect St.  
New Haven, Conn. 06520

BUDD N. SHENKIN, M.D.  
DAVID C. WARNER, Ph.D.

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Dr. Cobb is survived by his widow, two daughters and seven grandchildren.

**Flynn** — William F. Flynn, M.D., of Milton, died on June 9. He was in his 65th year.

Dr. Flynn received his degree from Yale University School of Medicine in 1933. He was a member of the staffs of Milton and Carney hospitals. He was assistant clinical professor of surgery at Harvard Medical School and a member of the surgical service of Boston City Hospital. He was a fellow of the American College of Surgeons and a member of the American Society for Surgery of the Hand and the American Medical Association and a councilor of the Massachusetts Medical Society.

Dr. Flynn is survived by his widow, four sons, a daughter, three sisters, a brother and a grandchild.

**Halpin** — Thomas F. Halpin, M.D., of Reading, died on July 1. He was in his 68th year.

Dr. Halpin received his degree from Tufts College Medical School in 1930. He was a member of the staff on Bridgewater State and Foxboro State hospitals. He was a member of the American Medical Association.

Dr. Halpin is survived by his widow, three daughters, a son, a sister and thirteen grandchildren.

**Keene** — Carroll H. Keene, M.D., of Chatham, died on June 5. He was in his 75th year.

Dr. Keene received his degree from Boston University School of Medicine in 1925. He was an honorary member of the staff of Cape Cod Hospital and a past president of the Barnstable District Medical Society. In 1961 he was nominated as Doctor of the Year by the Barnstable District Medical Society. He was Barnstable County Medical Examiner and a member of the Chatham Board of Health. He was a member of the American Medical Association.

Dr. Keene is survived by his widow, two sons, one brother and six grandchildren.

**Knapp** — Allen H. Knapp, M.D., of Westboro, died on June 22. He was in his 64th year.

Dr. Knapp received his degree from Yale University School of Medicine in 1935. He was a member of the staffs of Marlboro, St. Vincent and University hospitals. He was a member of the American Medical Association.

Dr. Knapp is survived by his widow, a daughter and a sister, and seven grandchildren.

**Myers** — Robert S. Myers, M.D., of Pinehurst, North Carolina, died on July 9. He was in his 63d year.

Dr. Myers received his degree from Harvard Medical School in 1937. He was an instructor in surgery at Harvard Medical School from 1941 to 1950 and assistant surgeon to the Harvard College Health Department from 1942 to 1950. He was executive assistant director of the American College of Surgeons from 1951 to 1965. He was a fellow of the American College of Surgeons and a member of the American Medical Association.

Dr. Myers is survived by his widow, two daughters, a brother, a sister and three grandchildren.

**Nickerson** — Donald A. Nickerson, M.D., of Melrose, died on June 20. He was in his 65th year.

Dr. Nickerson received his degree from Tufts College Medical School in 1933. He was chief pathologist, director of laboratories and



## MASSACHUSETTS MEDICAL SOCIETY

### DEATHS

**Bova** — Alexander W. Bova, M.D., of Andover, died on June 23. He was in his 47th year.

Dr. Bova received his degree from Georgetown University School of Medicine in 1954. He was a member of the staffs of Melrose, Wakefield, Winchester and New England Memorial hospitals. He was a member of the American Society of Abdominal Surgeons and the American Medical Association.

Dr. Bova is survived by his widow, four daughters, four sons and a sister.

**Cobb** — Chester T. Cobb, M.D., of Bedford, died on July 14. He was in his 92d year.

Dr. Cobb received his degree from Albany Medical College of Union University in 1904. He was formerly surgeon at the Cooley Dickinson Hospital and medical director for the Prophylactic Brush Company. He was a member of the American Medical Association and a 50-year member of the Massachusetts Medical Society.



UNITED STATES COURT OF APPEALS  
FOR THE SECOND CIRCUIT

JANET GOTKIN and PAUL GOTKIN, individually and  
on behalf of all persons similarly situated,

*Plaintiff*

*against*

ALAN D. MILLER, individually and as Commissioner of  
Mental Hygiene of the State of New York, MORTON B.  
WALLACH, individually and as Director of Brooklyn  
State Hospital, et al.

*Defendant*

*Index No.*    *Docket No.* 74-2138

*Affidavit of Personal Service*

STATE OF NEW YORK, COUNTY OF  
NEW YORK

SS.:

PERLA D. RAMIREZ

*being duly sworn,*

*deposes and says that deponent is not a party to the action, is over 18 years of age and resides at*

11 Waverly Pl. E. New York, N.Y. 1000e  
*That on the* 15th *day of* Jan.

19 75 at 114 Old Country Rd.

*deponent served the annexed* ADDENDUM TO BRIEF OF HOSPITAL ASSO.

*upon*

Lippe Ruskin and Schissel

*the Attys. for defendants in this action by delivering a true copy thereof to said individual personally. Deponent knew the person so served to be the person mentioned and described in said papers as the* Counsels *herein,*

SANDRA LEE HILE  
Notary Public, State of New York  
No. 30-4513207  
Qualified in Nassau County  
Certificate filed in Nassau County  
Commission Expires March 30, 1975

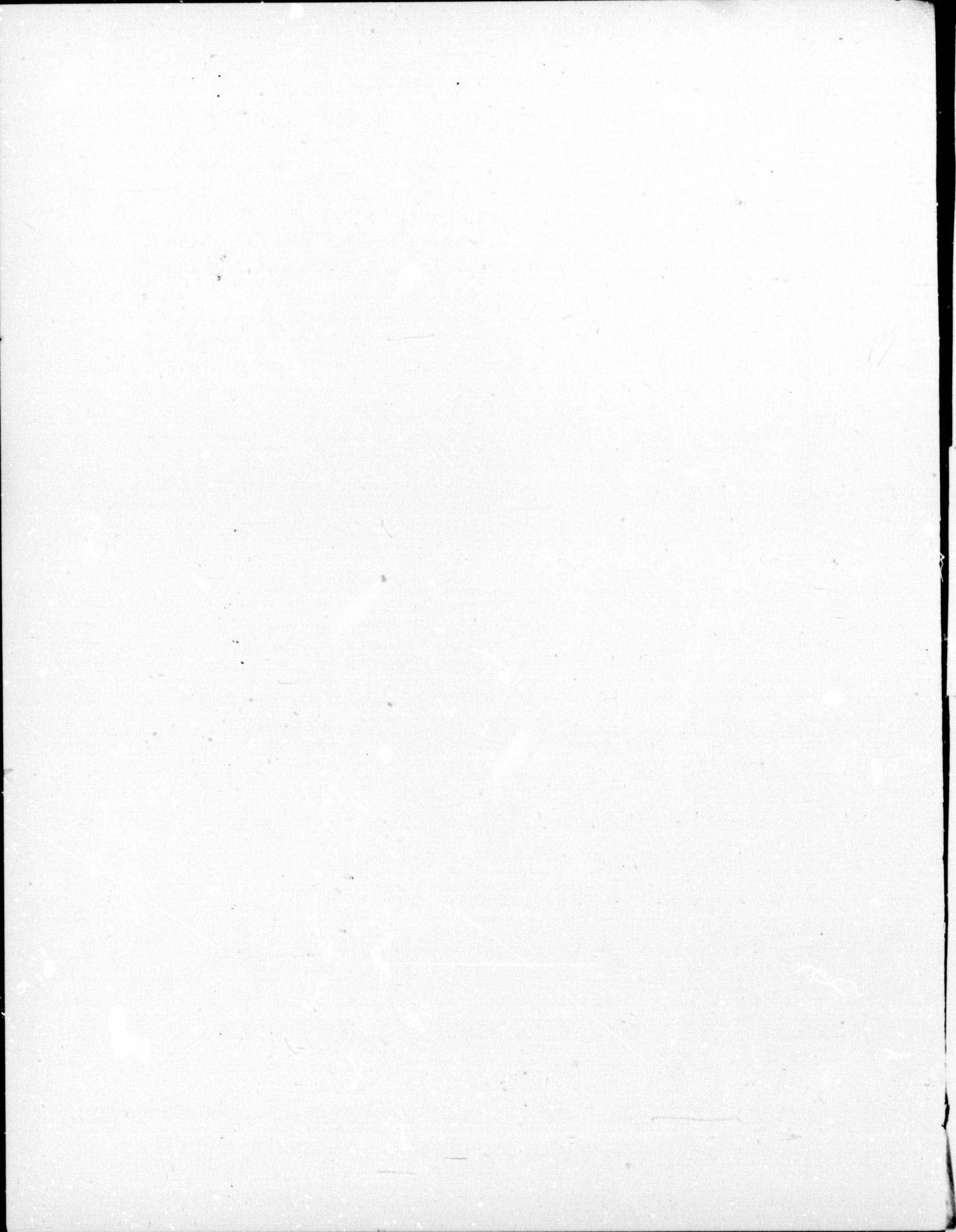
*Sworn to before me, this*

*day of* 16th *day of* Jan. 19 75

*Sandra Hile*

*Perla D. Ramirez*

Print name beneath signature  
Perla D. Ramirez



Copy received  
1/16/75  
Goldwater + Flynn  
by [signature]

Copy received  
1/16/75  
Mental Health  
Law Project  
by Delmar Stead

COPY OF THE WITHIN PAPER  
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DEPARTMENT OF LAW

JAN 16 1975

NEW YORK CITY OFFICE  
*Harris J. Raskovsky*  
ATTORNEY GENERAL